PATIENT MEDICAL HISTORY

Date:______________________

Patient's Name: ____
Please print

Employer: ___________________________ **Occupation:** ________________________

Please select one: ☐ **Smoker** ☐ **Non-Smoker**

Who referred you?
☐ Physician ☐ Insurance ☐ Family Member
☐ Phone Book ☐ Advertisement ☐ Friend ____________________________

Please answer questions 1-8 in regards to your single most important dermatologic problem:

1. **What is your current skin condition that you are seeing the physician for today?** _
____
____
____

2. **How long have you had your skin condition and has it changed over time?** ______
____
____
____

3. **Where on you body is the problem located?**_________________________________
____
____

4. **Does your skin condition itch, burn, sting, hurt, other** (specify including severity)?
____
____
____

5. **Please list all current and previous treatment for the skin condition:**
____
____

6. **Does anything seem to make your skin condition better or worse? (specify)**
____
____
____

Patient's Name: ____

Please list all of your current medications (including over the counter medications) that you are taking for all your medical problems.

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____

Please list all allergies or bad reactions to medications or any substances (describe reaction):

____

____

Check yes or no for YOUR past and present personal health history.
(Do not include family history).

YES	NO	
☐	☐	Personal history of skin cancers, precancerous (actinic keratosis) or melanomas. Specify type: ____________________ Specific treatments: ____________________
☐	☐	Heart disease including valve problems, pacemaker, angina or other__________
☐	☐	Abnormal bleeding or clotting
☐	☐	Tendency to form large scars or keloids
☐	☐	Diabetes or high blood sugar
☐	☐	History of cold sores, fever blisters.
☐	☐	High blood pressure (Hypertension)
☐	☐	History of hepatitis, liver disease or jaundice
☐	☐	Stomach ulcer or other gastrointestinal problems (specify)__________
☐	☐	Asthma or other respiratory problems (specify) __________
☐	☐	Arthritis (specify) __________
☐	☐	Kidney or urinary problems (specify) __________
☐	☐	History of internal cancer (specify) __________
☐	☐	Neurological or psychiatric problems (specify) __________
☐	☐	Glaucoma or other eye problems (specify) __________
☐	☐	Hay fever
☐	☐	Recent fevers, sweats, or chills (specify) __________
☐	☐	Any hormonal problems (specify) __________
☐	☐	Known to be HIV positive
☐	☐	At risk for HIV infection * (Aids Virus Infection) e.g. previous blood transfusions, homosexual activity, IV drug abuse, multiple partners, sexual contacts at risk (specify) __________
☐	☐	Other information pertinent to your health NOT listed above (specify) __________

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Completed By: ☐ **Patient**
☐ **Nurse/MA**

______________________ **Provider's Signature**

______________ **Date**