DERMATOLOGY HISTORY FORM

Date_____

Name_____ Date of Birth _____ Height_____ Weight_____

1. How were you referred to us?
   ____ Friend ____Doctor _____ Internet _____ Yellow Pages _____Other
2. Primary reason for today's visit?_____
3. How long have you had the problem?_____
4. What treatment have you tried both nonprescription and/ or prescription?
   _____
5. Do you have or have you ever had any of the following: Review of Systems: (ROS)

LUNG

Yes	No	
___	___	Bronchitis
___	___	Emphysema
___	___	Asthma
___	___	Do you smoke
_____		When was your last Flu shot?

VASCULAR

Yes	No	
___	___	High Blood Pressure
___	___	Heart Attack
___	___	Heart murmur/Rheumatic Fever
___	___	Palpitation/Irreg. or fast heart beat
___	___	Heart disease, angina or chest pain
___	___	Artificial Pacemaker/Defibrillator
___	___	Stroke

SYSTEMIC

Yes	No	
___	___	Diabetes
___	___	Thyroid trouble
___	___	Kidney or bladder problems
___	___	Stomach or bowel problems
___	___	Hepatitis, jaundice, liver disease
___	___	Convulsions or epilepsy
___	___	Fainting
___	___	Glaucoma
___	___	Alcoholism
___	___	Hepatitis B Exposure
___	___	AIDS or HIV Exposure
___	___	Cancer
___	___	Blood Transfusion
___	___	Do you drink alcohol?

If yes,
How many:____per day, ____per week

For Office Use
Reviewed by:

(1) _____ Date Signature
(2) _____ Date Signature
(3) _____ Date Signature
(4) _____ Date Signature
(5) _____ Date Signature
(6) _____ Date Signature
(7) _____ Date Signature
(8) _____ Date Signature
(9) _____ Date Signature
(10) _____ Date Signature
(11) _____ Date Signature
(12) _____ Date Signature
(13) _____ Date Signature
(14) _____ Date Signature
(15) _____ Date Signature
(16) _____ Date Signature
(17) _____ Date Signature
(18) _____ Date Signature
(19) _____ Date Signature
(20) _____ Date Signature

6. Current medication and dosage, include over the counter, and vitamins_____
   _____
   _____
   _____
   (If you need additional space please check with the receptionist)
7. Do you have any medication allergies? Yes _____ No _____
   List: _____
8. Other Medical Conditions or Surgeries not already listed?_____
   _____
9. Any personal history of skin cancer? ____Yes ____No
   If yes, Type (If you know) _____
10. Any personal history of other skin disease? ___Yes ___No
    If yes, What _____
11. Any family history of skin cancer? ____ Yes ____ No
    If yes, What _____
12. Any family history of skin disease? ____ Yes ____ No
    If yes, What _____
13. Do you have any scarring tendencies after surgery? ____Yes ___No
    _____
14. Women Only: Are you pregnant? ___Yes ___No If yes, Due Date _____
    When was your last menstrual period? _____

Completed By: ___ Patient ___Parent/ Guardian

_____
Signature