DERMATOLOGY MEDICAL HISTORY FORM

Name (Printed): _____DOB:_____Height: _____ Weight: _____

General Medical History: Do you have or have you ever had any of the following?

Y N Pacemaker or Defibrillator Y N Asthma Y N Hay fever, seasonal allergies Y N Bronchitis Y N Eczema Y N Psoriasis Y N Diabetes, controlled with (Circle) diet, medication, insulin Y N High Cholesterol Y N High Blood Pressure Y N Angina/Coronary Artery disease Y N Congestive Heart Failure Y N Heart murmur or heart valve problem Y N Have you been told to take antibiotics before a dental procedure due to a heart murmur, heart valve, or artificial joint?	Y N Acne & or Rosacea Y N Scleroderma Y N Overgrown scars or keloids Y N Kidney problems (what type?) _____ Y N Epilepsy or seizures Y N Crohn's disease or ulcerative colitis Y N Arthritis (if yes, osteoarthritis, rheumatoid or psoriatic? Y N Thyroid problems (what type?) _____ Y N Osteoporosis Y N Organ transplant (what type?) _____ Y N Fibromyalgia Y N Reflux/GERD/Heartburn or peptic ulcers Y N Emphysema or COPD Y N Melanoma (if yes, year_____ location_____) Y N Basal cell or Squamous cell skin cancer (if yes, year _____ location _____)	Y N Sarcoid Y N HIV or AIDS Y N Hepatitis (what type?) _____ Y N Multiple sclerosis Y N Lupus (circle) Systemic/Discoid Y N Liver cirrhosis or other liver problems Y N Herpes (circle) genital/mouth/ shingles Y N Genital warts Y N Blistering sunburns Y N Tuberculosis Y N Blood clots in legs (DVT) Y N Anemia (circle) Iron or Folate Y N Blood transfusion (when_____) Y N Bleeding disorder, type _____ Y N Anxiety Y N Depression or other psychological condition, type _____ Y N Cancer (type_____ when _____ how treated? _____
Surgeries: Y N Abnormal moles proven on biopsy Y N Heart valve replacement	Y N Artificial joint (if so, where_____/when_____	Y N Gallbladder removed Y N Heart bypass surgery
Female Patients: Y N Are you pregnant or breastfeeding, if not, method of birth control _____	Y N Are you planning to get pregnant If so, when _____ Y N Hysterectomy (if yes, uterus only or uterus and ovaries- circle one	Y N Prone to yeast infections with antibiotics Y N Tubal ligation (tubes tied

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Any prior dermatology history?

_____

Other medical problems or surgeries?

_____

_____

Current medications being taken (include prescription and non-prescription and herbal)? Include strength and dosage amounts

_____

_____

_____

_____

Allergies to any medications or latex?

_____

_____

Have you had your flu shot? (Circle one) YES NO **Pneumonia vaccine? (Circle one)** YES NO

Do you have a living will? (Circle one) YES NO

Social History: Do you smoke or use tobacco? Y N Do you drink alcohol? Y N Number per day _____ week ____ year ____

Marital status _____ # of children _____Hobbies _____ Student? _____ Occupation_____

Family History: Circle any conditions affecting a *blood relative*. Specify who is affected below the circled answer.

Melanoma Basal cell or squamous cell skin cancer Breast cancer Psoriasis Eczema Acne

Lupus Sarcoid/Keloids Asthma Hay fever/allergies Rosacea

Signature of patient or parent/guardian of patient: _____

Printed Name: _____ **Date:** _____