DERMATOLOGY MEDICAL HISTORY FORM (7-4-17)

Name_____ Age_____ DOB_____Prefer to be called_____

Height_____ Weight_____ **Did a doctor recommend that you see a dermatologist?** No Yes, Dr._____

For my prescription medications, I prefer (circle one): Brand only Generic only Either Brand or Generic would be fine

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

Y	N	Pacemaker or defibrillator	Y	N	Acne &/ or Rosacea (circle)	Y	N	HIV or AIDS
Y	N	Asthma	Y	N	Overgrown scars or keloids	Y	N	Hepatitis (what type?) A B C
Y	N	Hayfever, seasonal allergies	Y	N	Kidney problems (what type?)	Y	N	Liver cirrhosis or other liver problems
Y	N	Eczema	Y	N	Epilepsy or seizures	Y	N	Herpes-(circle) genital or mouth
Y	N	Psoriasis	Y	N	Crohn's disease or ulcerative colitis	Y	N	Genital warts
Y	N	Diabetes, controlled with (circle): diet, medication, insulin	Y	N	Arthritis (if yes, osteoarthritis, rheumatoid, or psoriatic?)	Y	N	Blistering sunburns (how many and where on body?)
Y	N	High cholesterol	Y	N	Thyroid problem (what type?)	Y	N	Tuberculosis
Y	N	High blood pressure	Y	N	Osteoporosis	Y	N	Blood clots in legs (DVT)
Y	N	Stroke	Y	N	Organ transplant (what type?)	Y	N	Anemia
Y	N	Heart attack	Y	N	Fibromyalgia	Y	N	Blood transfusion (when)
Y	N	Angina/ Coronary artery disease	Y	N	Reflux/ GERD/ Heartburn or peptic ulcers	Y	N	Bleeding disorder
Y	N	Congestive heart failure	Y	N	Emphysema or COPD	Y	N	Anxiety
Y	N	Heart murmur or heart valve problem	Y	N	Melanoma	Y	N	Depression
Y	N	Have you been told to take antibiotics before dental procedures due to a heart murmur, heart valve, or artificial joint?	Y	N	Basal cell or squamous cell skin cancer (where on body, when treated?)	Y	N	Cancer (what type, how treated, and when?)

Surgeries:

Y	N	Abnormal moles proven on biopsy	Y	N	Artificial joint (If yes, which one & when?)	Y	N	Gallbladder removed
Y	N	Heart valve replacement	Y	N	Appendix removed	Y	N	Heart bypass surgery
Female Patients:			Y	N	Are you planning to get pregnant? If yes, when:_____	Y	N	Prone to yeast infections with antibiotics
Y	N	Are you pregnant or breastfeeding? If not, method of birth control: _____	Y	N	Hysterectomy (if yes, uterus only or uterus and ovaries?)	Y	N	Tubal ligation (tubes tied)

Other Medical Problems or Surgeries:_____

_____

Allergies to medications and type of allergic reaction (example: hives, difficulty breathing, swelling)_____

_____

Medications (Prescription, Non-Prescription, Vitamins, Herbs):_____

_____

_____

Skin Type: If 1st exposed to the sun in the summer without sunscreen, would you: 1. always burn, never tan 2. always burn, sometimes tan 3. sometimes burn, always tan gradually 4. burn minimally, always tan well 5. rarely burn, tan profusely 6. never burn, deeply pigmented

Social History: Do you smoke or use tobacco? Y N Do you drink alcohol? Y N Number per day____ per week____ per year____

Marital status:_____ Children:_____ Hobbies:_____Occupation/ School:_____

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

Melanoma Basal cell or squamous cell skin cancer Breast Cancer Psoriasis Eczema Hayfever or allergies Asthma Acne

I would like more information about (circle):

Fillers such as Restylane, Radiesse, Juvederm, Lyft, Silk, Voluma, Sculptra, to treat winkles or volumize areas

Botox/ Dysport (to treat wrinkles between the eyebrows, around the eyes, forehead, neck)

Facial spider veins, "broken" blood vessels, or redness of the face

Spider veins on the legs

Brown spots (liver spots) or discoloration on the face, hands, chest, arms

Kybella—improves the "double chin"

Cosmetic Mole or skin tag removal

Dark circles or deep tear troughs, sunken eyes

Microdermabrasion

Chemical peels, Facials

Tattoo Removal

Laser hair removal

Skin care/ Anti-aging products

Signature of person filling out this form_____**Today's date**_____

Updated_____