Dermatology Medical History

Patient:_____ Date:_____

Drug Allergies:_____

Current Medications (including over-the-counter):

1._____ 6._____ 11._____

2._____ 7._____ 12._____

3._____ 8._____ 13._____

4._____ 9._____ 14._____

5._____ 10._____ 15._____

Do you have now, or have you ever had diseases or conditions of:

Skin:	**YES**	**NO**	**Systemic:**	**YES**	**NO**
Atopic Dermatitis/Eczema	☐	☐	Artificial Heart Valve	☐	☐
Skin Cancer (not melanoma)	☐	☐	Artificial Joint	☐	☐
Malignant Melanoma	☐	☐	Heart Murmur	☐	☐
Fever blister/cold sore on face	☐	☐	Pacemaker	☐	☐
Peanut allergy	☐	☐			
Women:			AIDS (HIV)	☐	☐
Abnormal Menstrual Periods	☐	☐	Arthritis	☐	☐
Hysterectomy	☐	☐	Asthma	☐	☐
Ovarian Cysts	☐	☐	Blood clots	☐	☐
Are you currently pregnant?	☐	☐	Cancer (not skin)*	☐	☐
			Diabetes	☐	☐
Family Medical History:			Hepatitis/Liver problem	☐	☐
Parent, sibling or child had melanoma?	☐	☐	Thyroid	☐	☐

*List cancer (other than skin):_____

Other medical conditions:_____

Social History:

Do you drink alcohol? ☐ YES ☐ NO If YES, _____ drinks per day

Do you smoke? ☐ YES ☐ NO If YES, how much?_____

What is your occupation?_____

_____

Signature