



# CENTER FOR DERMATOLOGY

## Medical History Form

Please complete both sides of the questionnaire

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_/\_\_\_\_\_

What is the reason for your visit today? How long has the condition been present? Any prior treatment?

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List current medications (prescription and over the counter)  None

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What is your preferred pharmacy? \_\_\_\_\_

List allergies to medications:  None

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Problems with the following?  latex  local anesthetics  epinephrine  tape/band-aids

Are you on blood thinners?  No  aspirin  ibuprofen  coumadin  plavix  Other \_\_\_\_\_

### Check the box if you experience any of the following:

- |                  |   |  |                                       |  |
|------------------|---|--|---------------------------------------|--|
| Eye              | <input type="checkbox"/> blurred vision | <input type="checkbox"/> double vision       |                                       |  |
| Ears             | <input type="checkbox"/> drainage       | <input type="checkbox"/> hearing loss        | <input type="checkbox"/> pain         | <input type="checkbox"/> ringing             |
| Renal            | <input type="checkbox"/> burning        | <input type="checkbox"/> frequency           | <input type="checkbox"/> incontinence | <input type="checkbox"/> pain                |
| Respiratory      | <input type="checkbox"/> cough          | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> wheezing     |  |
| Cardiovascular   | <input type="checkbox"/> chest pain     | <input type="checkbox"/> palpitations        | <input type="checkbox"/> leg edema    | <input type="checkbox"/> shortness of breath |
| Gastrointestinal | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> diarrhea            | <input type="checkbox"/> nausea       | <input type="checkbox"/> constipation        |
| Neurological     | <input type="checkbox"/> headaches      | <input type="checkbox"/> weakness            | <input type="checkbox"/> dizziness    | <input type="checkbox"/> confusion           |
| Psychiatry       | <input type="checkbox"/> anxiety        | <input type="checkbox"/> depression          | <input type="checkbox"/> mood changes |  |
| Musculoskeletal  | <input type="checkbox"/> weakness       | <input type="checkbox"/> leg cramps          | <input type="checkbox"/> pain         |  |

**Do you have now or in the past any of the following? If yes, please explain**

- No  Yes Abnormal Moles \_\_\_\_\_
- No  Yes Precancerous growths \_\_\_\_\_
- No  Yes Skin Cancer \_\_\_\_\_
- No  Yes Cancer (other than skin) \_\_\_\_\_
- No  Yes High Blood Pressure \_\_\_\_\_
- No  Yes High Cholesterol \_\_\_\_\_
- No  Yes Heart disease \_\_\_\_\_
- No  Yes Nerve disease or stroke \_\_\_\_\_
- No  Yes Gastrointestinal disease \_\_\_\_\_
- No  Yes Kidney disease \_\_\_\_\_
- No  Yes Diabetes \_\_\_\_\_
- No  Yes Bleeding or clotting disorder \_\_\_\_\_
- No  Yes Mental Health disorder \_\_\_\_\_

**Social History**

Do you drink alcohol?  No  Yes If yes, how many drinks per day? \_\_\_\_\_

Do you smoke cigarettes?  No  Fomer  Yes

If yes, how many per day? \_\_\_\_\_

If former, when did you quit smoking? \_\_\_\_\_

**Women Only**

Are you on birth control?  No  Yes, type \_\_\_\_\_

Have you had  hysterectomy  tubal ligation  endometrial ablation

Are you pregnant?  No  Yes, due date? \_\_\_\_\_

Trying to become pregnant?  No  Yes

Are you nursing?  No  Yes

Frequent yeast infections?  No  Yes

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Parent or guardian if patient is under 18*

Printed name \_\_\_\_\_ Date \_\_\_\_\_

*If completed by someone other than patient*