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?

____

____

List current medications (prescription and over the counter) ☐ None

____

____

What is your preferred pharmacy? ____

List allergies to medications: ☐ None

____

____

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	☐ blurred vision	☐ double vision		
Ears	☐ drainage	☐ hearing loss	☐ pain	☐ ringing
Renal	☐ burning	☐ frequency	☐ incontinence	☐ pain
Respiratory	☐ cough	☐ shortness of breath	☐ wheezing	
Cardiovascular	☐ chest pain	☐ palpitations	☐ leg edema	☐ shortness of breath
Gastrointestinal	☐ abdominal pain	☐ diarrhea	☐ nausea	☐ constipation
Neurological	☐ headaches	☐ weakness	☐ dizziness	☐ confusion
Psychiatry	☐ anxiety	☐ depression	☐ mood changes	
Musculoskeletal	☐ weakness	☐ leg cramps	☐ 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 ☐ Former ☐ 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