DERMATOLOGY MEDICAL HISTORY FORM

Name ________________________________ DOB ___/___/___ Reason for today's visit ____________________________________

Occupation ___________________________ Type of work _________________________

Any contributing factors to symptoms

General Medical History: (Please check boxes that apply)

No contributing history	☐	Heart Murmur	☐
Antibiotics prior to dental procedure	☐	Hepatitis	☐
Anticoagulants	☐	High Blood Pressure	☐
Artificial Joints	☐	HIV/AIDS	☐
Asthma	☐	Hives	☐
Bleeding Disorder	☐	Kidney Stones	☐
Breast Cancer	☐	Pacemaker/Defibrillator	☐
Cancer	☐	Stroke	☐
Diabetes	☐	Thyroid Disorder	☐
Eczema	☐	Tuberculosis	☐
Hay Fever/Seasonal Allergies	☐	X-Ray Therapy	☐
Heart Disease	☐		

Past Surgeries/Hospitalizations (If None, please print none)

Skin History: (Please circle choices that apply)

No contributing history
Actinic Keratosis
Basal Cell Carcinoma
Eczema
Malignant Melanoma
Other Suspicious Lesion
Psoriasis
Severe Sunburns
Squamous Cell Carcinoma
Tanning Bed Use
Urticaria

Family History: (Please circle choices that apply)

No contributing history	Unknown-Adopted	Autoimmune Disorders
Colon Cancer	Diabetes	Glaucoma
High Blood Pressure	High Cholesterol	Liver Disease
Lung Disease	Malignant Melanoma	Obesity
Premature Coronary Heart Disease	Skin Cancer	Thyroid Disease

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

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Current Medication: ____

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Social History: (Please answer choices that apply)

Smoking Status: **YES** **FORMER** **NEVER**

Started: __________________

Ended: ___________________

Signature of person filling out this form ____ Date __________________