ORMOND BEACH DERMATOLOGY
DERMATOLOGY MEDICAL HISTORY

Patient Name: _____ Date: _____/_____/_____

Reason for today's visit: _____

Are you allergic to any medications? ☐ **YES** ☐ **NO** If yes, list below:

1. _____ 2. _____

Have you ever had dental anesthesia (Novocain)? ☐ **YES** ☐ **NO** Any bad reaction? ☐ **YES** ☐ **NO**
List all medications **(INCLUDING DOSES)** you are currently taking (prescriptions, over-the-counter meds, vitamins,herbals):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**	**Other Systemic:**	**YES**	**NO**
Bronchitis	□	□	Diabetes	□	□
Emphysema	□	□	Excessive thirst/hunger	□	□
Asthma	□	□	Thyroid: Hypothyroidism	□	□
Chronic Cough	□	□	Hyperthyroidism	□	□
Morning Cough	□	□	Kidney	□	□
Shortness of Breath	□	□	Bladder	□	□
Wheezing	□	□	Frequency/Burning	□	□
			Hypercholesterolemia	□	□
Cardiovascular:			Gastrointestinal	□	□
High Blood Pressure	□	□	GERD	□	□
Chest Pain	□	□	Nausea, vomiting, diarrhea		
Heart Attack	□	□	when taking antibiotics	□	□
Heart Murmur	□	□	Yeast infection when taking antibiotics	□	□
Irregular Heartbeat	□	□	Arthritis/Joint Deformity	□	□
Phlebitis	□	□	**Artificial Joint** _____	□	□
Inflammation of vein	□	□	Convulsions, Epilepsy, or Seizures	□	□
Blood Clots	□	□	Fainting	□	□
Pacemaker	□	□	**Implantable Medical Device or "Stimulator"**	□	□

List any other diseases or conditions: _____

List surgical procedures you have had in the last year: _____

Skin:

Have you ever had skin cancer: ☐ **YES** ☐ **NO**
Has anyone in your family had skin cancer? ☐ **YES** ☐ **NO**
Do you have a history of specific skin diseases? ☐ **YES** ☐ **NO** If yes, _____
Do you have problems with healing? ☐ **YES** ☐ **NO**
Do you develop keloids (scars) after surgery? ☐ **YES** ☐ **NO**
Do you bleed easily? ☐ **YES** ☐ **NO**
Do you develop skin rashes in reaction to: ☐ Medications ☐ Food ☐ Environment? _____

Social History:

Do you drink alcohol? ☐ **YES** ☐ **NO** If yes, _____ drinks per day
Do you use IV drugs? ☐ **YES** ☐ **NO** If yes, what? _____ How often? _____
Do you smoke? ☐ **YES** ☐ **NO** If yes, how much? _____ Have you ever smoked? ☐ **YES** ☐ **NO**
Have you had or ever been exposed to HIV (AIDS)? ☐ **YES** ☐ **NO**

(Women) Are you pregnant? ☐ **YES** ☐ **NO** Due Date: _____/_____/_____

What is your occupation? _____ Hobbies? _____

Name of your primary care physician: _____

Completed by: ☐ Patient
☐ Medical Assistant _____
MA Initials

X_____ ____/____/____
PATIENT SIGNATURE (OR LEGAL GUARDIAN) **Date**

_____ ____/____/____
Reviewed By Date