Name:
Age: DOB:
DOS:
MRN: INS:
Doctor:

DERMATOLOGY SPECIALISTS

Medical History Form

☐ Scan back of form

Primary Doctor/Clinic: _____ **Referred by your doctor? Yes / No**

Reason for today's visit: _____

Do you have cosmetic concerns? Yes / No Circle: Botox, Voluma, Juvederm, Veins, Hair removal, Wrinkles, Brown spots

ALLERGIES: _____

MEDICATIONS: _____

Skin Conditions and Social History	Yes	No
Have you had skin cancer?	☐	☐
Melanoma?	☐	☐
Basal Cell Carcinoma?	☐	☐
Squamous Cell Carcinoma?	☐	☐
Have you had abnormal / dysplastic moles?	☐	☐
Have you had pre-cancerous Actinic Keratoses?	☐	☐
List any other skin conditions you have: _____ (Examples: Eczema, Psoriasis, Acne, Rosacea, Vitiligo)		
Do you use sunscreen? SPF #_____	☐	☐
Have you used a tanning bed more than 25 times in your life? Total #_____	☐	☐
Have you had blistering sunburns?	☐	☐
Do you heal with thick (keloid) scars?	☐	☐
Do you bleed / bruise easily?	☐	☐
Are you sensitive to bandages or adhesive?	☐	☐
Do you need antibiotics for dental appointments?	☐	☐
Have you had staph infections / MRSA?	☐	☐
Do you smoke? # cigarettes/day_____	☐	☐
Do you drink alcohol? # drinks/day_____	☐	☐
Have you worked outdoors?	☐	☐
Gender identity: _____		
List any foreign countries you have visited in the past six months: _____		
Occupation: _____		
Hobbies: _____		

ROS: Circle any *Symptoms* you currently have:

General	weight loss	fatigue
Immune	fever night sweats	frequent infections
Eye	dryness blurry vision	irritation
Heart	chest pain ankle swelling	palpitations
Lungs	shortness of breath	cough
GI	nausea vomiting	diarrhea
Joint	stiffness pain	cramping
Neuro	numbness tingling headaches	weakness
Endocrine	heat/cold intolerance	excessive thirst
Psych	depression	anxiety
Heme	easy bleeding bruising	swollen nodes
Skin	itch burning redness discoloration	scale
Females	pregnant nursing	irregular periods
	planning pregnancy IUD	birth control pills

PAST Surgeries:	Yes	No
Pacemaker / Defibrillator	☐	☐
Joint replacement-Site: _____	☐	☐
Heart valve replacement	☐	☐
Organ transplant-Type: _____	☐	☐
Tubal ligation	☐	☐
List other surgeries: _____		

PERSONAL Past Medical History: Please circle

Cancer	breast prostate colon _____	
Immune	HIV immune deficiency	
Eye	glaucoma cataract	rosacea
Nose	seasonal allergies	chronic rhinitis
Heart	high blood pressure	heart attack
	high cholesterol	atrial fibrillation
	heart valve problems	clotting disorder
Lung	COPD asthma	tuberculosis
GI	acid reflux colitis	irritable bowel
	Hepatitis B or C	
Joint	arthritis joint replacement	
Brain	stroke seizures migraine	headaches
Endocrine	thyroid diabetes	polycystic ovary
Psych	depression anxiety	attention deficit
OTHER		

FAMILY Medical Problems:	Yes	No
Skin cancer	☐	☐
Melanoma?	☐	☐
Basal Cell Carcinoma?	☐	☐
Squamous Cell Carcinoma?	☐	☐
Abnormal moles	☐	☐
Eczema	☐	☐
Asthma	☐	☐
Seasonal Allergies	☐	☐
Psoriasis	☐	☐
Autoimmune diseases	☐	☐
(lupus, rheumatoid arthritis, MS, Crohn's, colitis, thyroid)		

Have you received the COVID-19 vaccine? *Circle one*

Yes No Decline to answer

Patient signature: _____ Date: _____

Doctor signature: _____ Date: _____