# DERMATOLOGY MEDICAL HISTORY

Patient Name: ____________________________________ Date: _______________________________________________

Referring Physician (if any):________________________________________________________________________________

| Question | | |
|---|---|---|
| • Do you have an allergy to adhesive? | **Yes** | **No** |
| • Do you have an allergy to lidocaine? | **Yes** | **No** |
| • Do you have an allergy to topical antibiotics ointments? | **Yes** | **No** |
| • Do you have an artificial heart valve? | **Yes** | **No** |
| • Artificial joints within the past two years? | **Yes** | **No** |
| • Are you taking blood thinners? | **Yes** | **No** |
| • Do you have a defibrillator? | **Yes** | **No** |
| • Do you have a pacemaker? | **Yes** | **No** |
| • Are you pregnant or planning to become pregnant? | **Yes** | **No** |
| • Have you had MRSA in the past? | **Yes** | **No** |
| • Are you breastfeeding? | **Yes** | **No** |
| • Do you have a history of skin cancer? | **Yes** | **No** |
| • Do you have a family history of skin cancer? | **Yes** | **No** |
| • Have you had a lot of sun exposure? | **Yes** | **No** |
| • Have you had exposure to tanning beds or PUVA? | **Yes** | **No** |
| • Do you consume alcohol? | **Yes** | **No** |
| • Are you a smoker? | **Yes** | **No** |
| • If not, did you used to smoke? | **Yes** | **No** |
| • Do you consume caffeine? | **Yes** | **No** |

**PLEASE LIST ALL CURRENT MEDICATIONS AND DRUG ALLERGIES IN THE AREA PROVIDED BELOW. PLEASE INCLUDE ALL OVER THE COUNTER MEDICINE, VITAMINS, AND HERBAL THERAPIES.**

Drug Allergies: ______________________________________________________________________________________

Medications: ________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

**PLEASE COMPLETE THE INFORMATION ON PAGE 2 OF THIS FORM**

## DERMATOLOGY REVIEW OF SYSTEMS

| | | | | | |
|---|---|---|---|---|---|
| Problems with bleeding | **Yes** | **No** | Anxiety | **Yes** | **No** |
| Problems with healing | **Yes** | **No** | Depression | **Yes** | **No** |
| Problems with scarring | **Yes** | **No** | Headaches | **Yes** | **No** |
| Rash | **Yes** | **No** | Seizures | **Yes** | **No** |
| Immunosuppression | **Yes** | **No** | Cough | **Yes** | **No** |
| Hay Fever | **Yes** | **No** | Shortness of Breath | **Yes** | **No** |
| Chest Pain | **Yes** | **No** | Wheezing | **Yes** | **No** |
| Thyroid Problems | **Yes** | **No** | Joint Aches | **Yes** | **No** |
| Abdominal Pain | **Yes** | **No** | Neck Stiffness | **Yes** | **No** |

Other Medical Conditions:_______________________________________________________________________________

_______________________________________________________________________________________________

# Past Surgical History

| | | | | | |
|---|---|---|---|---|---|
| Abdominoperineal Resection | **Yes** | **No** | Lumpectomy of Breast: Left | **Yes** | **No** |
| Bilateral replacement of knee joints | **Yes** | **No** | Lumpectomy of Breast: Right | **Yes** | **No** |
| Biopsy of Breast | **Yes** | **No** | Mastectomy of Breast: Left | **Yes** | **No** |
| Biopsy of Prostate | **Yes** | **No** | Mastectomy of Breast: Right | **Yes** | **No** |
| Coronary Artery Bypass Graft | **Yes** | **No** | Mechanical Heart Valve | **Yes** | **No** |
| Transplanted Kidney | **Yes** | **No** | Total Nephrectomy (Kidney) | **Yes** | **No** |
| Excision of Basal Cell Carcinoma | **Yes** | **No** | Oophorectomy | **Yes** | **No** |
| Excision of Melanoma | **Yes** | **No** | Pancreatectomy | **Yes** | **No** |
| Excision of Squamous Cell Carcinoma | **Yes** | **No** | Kidney Stone Extraction | **Yes** | **No** |
| Colostomy | **Yes** | **No** | Portosystemic Shunt Operation | **Yes** | **No** |
| Tubal Ligation | **Yes** | **No** | Prostatectomy | **Yes** | **No** |
| Appendectomy | **Yes** | **No** | Prosthetic arthroplasty of hips | **Yes** | **No** |
| Bilateral Mastectomy | **Yes** | **No** | Splenectomy | **Yes** | **No** |
| Cholecystectomy (Gallbladder) | **Yes** | **No** | Surgical Biopsy of Skin | **Yes** | **No** |
| Colectomy | **Yes** | **No** | Total Orchidectomy | **Yes** | **No** |
| Liver Excision | **Yes** | **No** | Transplantation of Liver | **Yes** | **No** |
| Heart Valve Replacement (Tissue Graft) | **Yes** | **No** | Replacement of Left Hip | **Yes** | **No** |
| Total Cystectomy | Yes | **No** | Replacement of Right Hip | **Yes** | **No** |
| Transurethral Prostatectomy | **Yes** | **No** | Replacement of Left Knee | **Yes** | **No** |
| Hysterectomy | **Yes** | **No** | Replacement of Right Knee | **Yes** | **No** |
| Kidney Biopsy | **Yes** | **No** | Transplantation of heart | **Yes** | **No** |
| Low Anterior Resection of Rectum | **Yes** | **No** | | | |

Other Surgical History: ____________________________________________________________________________

**I confirm there are no changes or updates to this form    Initial: ______    Date:_______

**PLEASE COMPLETE THE INFORMATION ON PAGE 1 OF THIS FORM**