

MEDICAL HISTORY

Name _____ Date _____

Male Female Date of Birth _____ Age _____

Chief Complaint (reason for visit) _____

Did a physician recommend that you see a Dermatologist for this condition? No Yes

Doctor's Name: _____

History of Present Illness:

Duration of condition _____ Symptoms _____

Past treatment _____ Current treatment _____

List **all** current medications (including over the counter)

List all medication or environmental **ALLERGIES**

Past Medical History (past or current medical illnesses):

Circle if yes:

ASTHMA	CANCER, type _____	KELOIDS / THICK SCARS
ARTIFICIAL HEART VALVE	ECZEMA _____	KIDNEY DISEASE
OR JOINTS	HAYFEVER	LIVER DISEASE
OR MITRAL VALVE PROLAPSE	HEPATITIS, type _____	PACEMAKER
BLEEDING TENDENCY	HIV	ULCERS

Dermatologic Medical History

History of Skin Cancer? No Yes (Basal cell carcinoma Melanoma Squamous cell carcinoma) Don't know

When Exposed To Sunlight, do you (circle one):

- 1. Always burn
- 2. Usually burn, rarely tan
- 3. Often burn, sometimes tan
- 4. Sometimes burn, tan well
- 5. Rarely burn, always tan
- 6. Never burn, deeply tan

Name _____

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Date of last total body skin check (approx.) _____

Have you had significant sun exposure in the past? No Yes

Number of blistering sunburns as a child: _____

Do you wear sunscreen daily? No Yes Only during outdoor activities? No Yes

Past Family and Social History

Is there a family history of:

skin cancer (basal cell, squamous, melanoma) asthma eczema psoriasis hair loss

hay fever/seasonal allergies genetic disease

Other _____

Patient occupation _____ Hobbies _____

Animals in the home _____ If smoker, # packs / day, # years _____

Alcoholic drinks per week _____

History of HIV, IV drug abuse, hepatitis C or blood transfusions? No Yes

Women only

Are you now or might you be pregnant? No Yes

Are you planning or attempting to become pregnant in the near future? No Yes

Are you taking Birth Control Pills? No Yes Brand _____

FOR OFFICE USE ONLY:

NDDA 06112010

Reviewed by _____, M.D.