

# CENTER FOR ADVANCED DERMATOLOGY

## Medical History

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_ Age: \_\_\_\_\_

Are you allergic to any medications?  Yes  No If yes, list below:

1. \_\_\_\_\_ 2. \_\_\_\_\_

Have you ever had numbing done at a dental office?  Yes  No Any bad reaction?  Yes  No

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

**Do you have now, or have you ever had diseases or conditions of: (check YES/ NO & circle if necessary)**

	Yes	No		Yes	No
<b>Lungs:</b>			<b>Other Systemic:</b>		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal (circle if applicable)		
<b>Cardiovascular:</b>	<b>Yes</b>	<b>No</b>	Nausea, vomiting, diarrhea, yeast	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Infections when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorder (Bipolar, Depression, Schizophrenia, Dementia)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pacemaker</b>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Special Needs</b>	<input type="checkbox"/>	<input type="checkbox"/>			

List any other diseases or conditions: \_\_\_\_\_

List surgical procedures you have had in the last 6 months: \_\_\_\_\_

**Skin:** When you are exposed to the sun do you:  Tan Only  Tan and Burn  Burn.  
Have you ever had skin cancer?  Yes  No Type? \_\_\_\_\_  
Has anyone in your family had skin cancer?  Yes  No Type? \_\_\_\_\_  
Do you have a history of any specific skin diseases?  Yes  No Type? \_\_\_\_\_  
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  Medication  Food  Environment  Bandages  Topical Neosporin  
 Other \_\_\_\_\_

### Social History:

Do you drink alcohol?  Yes  No If YES, drinks per day? \_\_\_\_\_ Per week? \_\_\_\_\_  
Do you use recreational/illicit drugs?  Yes  No If YES, what? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you use tobacco products?  Yes  No If YES, how much? \_\_\_\_\_  
Have you ever had or have you been exposed to HIV (AIDS)?  Yes  No

**(Women) Are you or are you planning to be pregnant?**  Yes  No Due Date: \_\_\_\_\_

What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Form Completed by: \_\_\_\_\_ Provider's Signature: \_\_\_\_\_ Date \_\_\_\_\_

(Reviewed On: \_\_\_\_\_ Init: \_\_\_\_\_ Reviewed On: \_\_\_\_\_ Init: \_\_\_\_\_ Reviewed On: \_\_\_\_\_ Init: \_\_\_\_\_)