DermacenterMD
Advanced Dermatology & Aesthetic Solutions

Medical History Form

Patient name: ______________________________ Date: ____________

Why are we seeing you today? ______________________________

When did this start? ____________________ What is the location? ____________

What symptoms are present? ___ none ___ itch ___ pain ___ other: specify______________

What treatment has been performed? ______________________________

Please check the following that apply to you:

____ I have a history of skin cancer
____ I have a family history of skin cancer
____ I have a history of melanoma
____ I have a family history of melanoma
___ I have had precancer lesions
___ I have had moles removed
___ I have freckles
___ I have had sunburns in past
___ I have had blistering sunburns
___ I have seasonal allergies
___ I have or had asthma
___ I have or had eczema
___ My family has eczema
___ Hypothyroid

If yes to the above, explain if needed: ______________________________

Do you use tobacco? ___ No ____ Yes - If yes how much/how long (in years)? ____________
Do you use alcohol? ___ No ____ Yes - If yes, how much? ____________

Do **you** have a personal history of the following conditions?

____ High blood pressure
____ Bleeding disorder
____ Pacemaker
____ Kidney disease
____ Lung disease
____ Heart disease
____ Photosensitivity (sun allergy)
____ Asthma
____ Hepatitis or liver problems
____ Rheumatic fever
____ Hypertrophic scars or keloids
____ Diabetes
____ Arthritis
____ Artificial joints
____ Gastrointestinal disorders or ulcers
____ Hay fever/Sinus problems (allergies)
____ HIV or AIDS
____ Collagen vascular disease
____ Artificial valves
____ Psoriasis
____ Skin Cancer or melanoma
____ Eczema
____ Rosacea
____ Depression
____ Connective tissue disorder (ie lupus, etc) Others: ______________________

Please check the following if anyone in your **family** has/had the following condition(s):

Circle: **M** – for mother; **F** – for Father; **S** – for sibling; or **C** – for children

	Condition				Condition				Condition	
____	Asthma	M F S C	____	Season allergies	M F S C	____	Eczema	M F S C
____	Actinic keratosis	M F S C	____	Heart problems	M F S C	____	Diabetes	M F S C
____	Arthritis	M F S C	____	Psoriasis	M F S C	____	Bleeding problem	M F S C
____	Acne	M F S C	____	Connective tissue disease (lupus, rheumatoid, scleroderma)				M F S C

Do you use any medications? Yes ____ No ____. If yes, complete the following:

Name of medication ____________________ ____________________
Name of medication ____________________ ____________________
Name of medication ____________________ ____________________

Do you have any medication allergies? ___ Yes ____ No If yes, list the medication and the kind of reaction:

____

Have you been hospitalized in the past five years for any medical problems or surgical procedures?
Yes ____ No ____. If yes, complete the following:

Hospitalization ______________________________ Date ____________
Hospitalization ______________________________ Date ____________
Hospitalization ______________________________ Date ____________

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