DERMATOLOGY MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Reason for today's visit: _____

Please list all medications you are currently taking (including prescription, over-the-counter medicines, vitamins, topicals, and herbals):

_____ _____ _____

_____ _____ _____

_____ _____ _____

DO YOU NOW, OR HAVE YOU EVER HAD DISEASES OR CONDITIONS OF: (CHECK YES OR NO)

	YES	NO
Allergy to adhesive	☐	☐
Allergy to Lidocaine	☐	☐
Allergy to topical antibiotic ointments	☐	☐
Artificial heart valve	☐	☐
Artificial joints within past 2 years	☐	☐
Blood thinners why?_____	☐	☐
Cancer – type_____how treated?_____	☐	☐
Defibrillator	☐	☐
Hepatitis – type A ◯ B ◯ C ◯ (circle one)	☐	☐
HIV	☐	☐
Immunosuppressed	☐	☐
MRSA	☐	☐
Pacemaker	☐	☐
Premedication prior to procedures	☐	☐
Rapid heartbeat with epinephrine	☐	☐
Pregnancy - _____weeks or planning on pregnancy	☐	☐
Problems with bleeding	☐	☐
Problems with healing	☐	☐
Problems with scarring – hypertrophic or keloids	☐	☐
Rash	☐	☐
Recent surgeries - type_____when_____	☐	☐
Transplant – type_____when_____	☐	☐
Unintentional weight loss	☐	☐
Do you smoke?	☐	☐
Do you get light headed of faint when a procedure is performed?	☐	☐

Are you hard of hearing yes no do you wear hearing aids?_____

Are you diabetic? yes no type_____

List any other diseases or conditions_____

_____

ALLERGIES:_____

_____

Have you ever had dental anesthesia (Novocaine) YES NO Any bad reactions: YES NO

Completed by: ____Patient _____RN Patient Signature:_____

_____Initials Date: _____

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