DERMATOLOGY HISTORY

Name _____ Date_____
Occupation _____ Age _____

CC & HISTORY OF PRESENT ILLNESS

List your skin problems	Their Location	How Long	Treatment

MEDICATIONS

What medicines do you take ? (include aspirin, laxatives, birth control pills, vitamins, creams, etc.)

ALLERGIES

Are you allergic to latex? ☐ YES ☐ NO
Are you allergic to any medicines? ☐ YES ☐ NO
If so, what? _____
Are you allergic to local anesthesia? ☐ YES ☐ NO

MEDICAL HISTORY ☐ YES ☐ NO

Do you require antibiotics before dental procedures? ☐ YES ☐ NO
Do you bleed easily? ☐ YES ☐ NO
Are you pregnant? ☐ YES ☐ NO

SKIN HISTORY

Have you had pre-cancer? ☐ YES ☐ NO
Have you had a skin cancer? ☐ YES ☐ NO
Have you had a melanoma (cancer in a mole)? ☐ YES ☐ NO
Has a sunburn ever caused water blisters? ☐ YES ☐ NO
Is so, where on the body? ☐ YES ☐ NO
Have you had a skin disease in the past? ☐ YES ☐ NO
If so, what? _____

FAMILY HISTORY

Has anyone in your family had skin cancer? ☐ YES ☐ NO
If so, who? _____
Has anyone in your family had a melanoma? ☐ YES ☐ NO
If so, who? _____
Has anyone in your family had a skin disease in the past? ☐ YES ☐ NO
If so, what? _____

SOCIAL HISTORY

Do you smoke? ☐ YES ☐ NO
Do you drink alcohol? ☐ YES ☐ NO

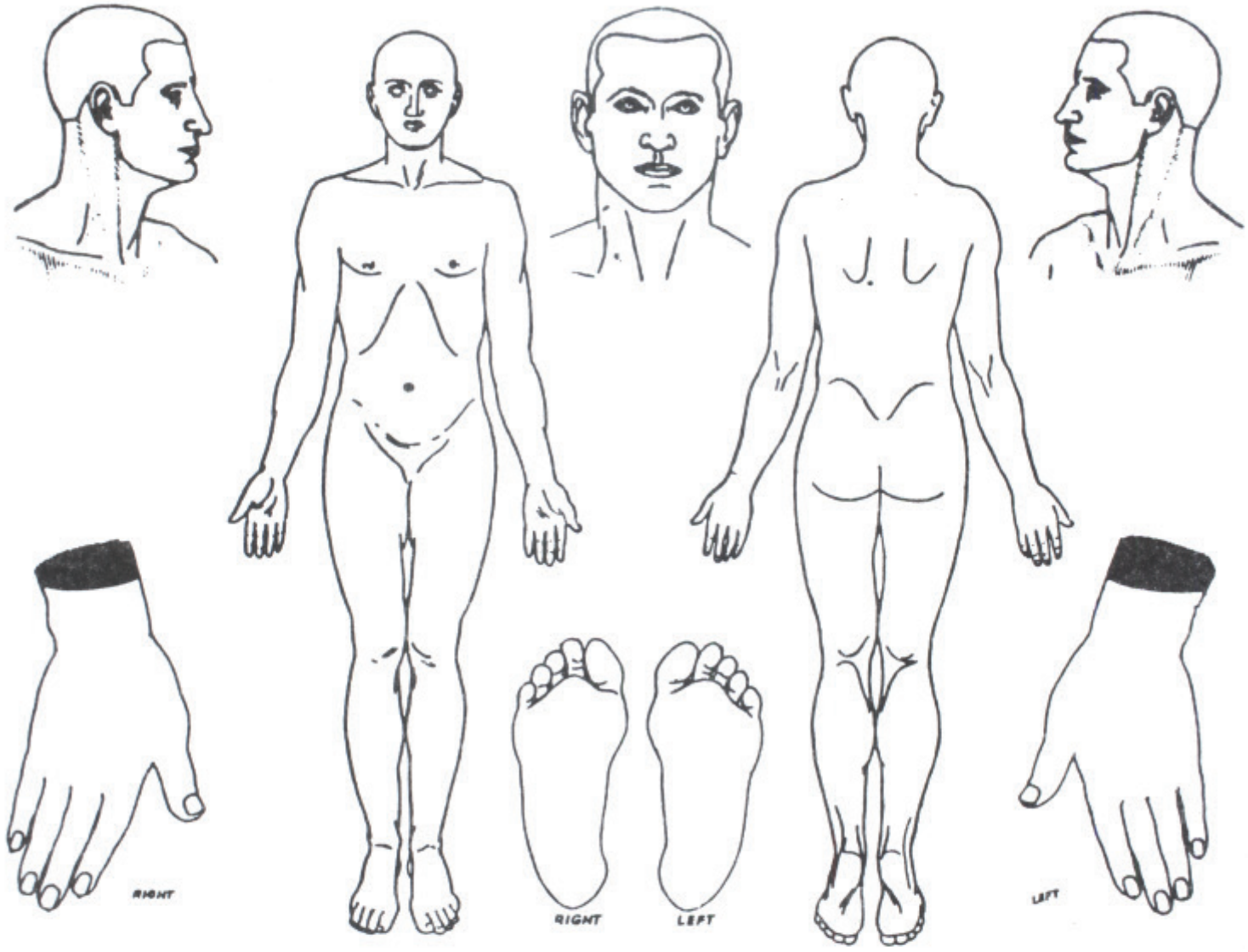
REVIEW OF SYSTEMS

PLEASE CHECK IF YOU HAVE:

- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Tuberculosis
- ☐ High Blood Pressure
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Heart Disease
- ☐ Asthma/Hay Fever
- ☐ Other Health Problems

_____
_____
_____
_____
_____

PLEASE DO NOT USE REVERSE SIDE


RIGHT
RIGHT
LEFT
LEFT