Bay Area Dermatology Medical History Form

PATIENT INFORMATION

NAME ______________________________________ **AGE** _____________ **Male** ☐ **Female** ☐

OCCUPATION _______________________________ **HOBBIES** _____________________ _____________________

Do you live alone? **Yes** ☐ **No** ☐ **Do you smoke? Yes** ☐ **No** ☐ **Smoked in the Past?** **Yes** ☐ **No** ☐

Do you drink alcohol? **Yes** ☐ **No** ☐ **How much?** ___________________ **Recreational Drug Use? Yes** ☐ **No** ☐

List current prescription medications ____

____

List any "Over the Counter Medications" ____

____

Pharmacy Used ____ **Pharmacy Phone** __________________

Do you take **Aspirin?** **Yes** ☐ **No** ☐ **Blood Thinners?** **Yes** ☐ **No** ☐

Any **ALLERGIES** to Medications ? **Yes** ☐ **No** ☐ **Yes, List** ____

____

Have you had an **Allergic Reaction** to local anesthetics? **Yes** ☐ **No** ☐ **Latex** **Yes** ☐ **No** ☐

FEMALES ONLY **Are you pregnant?** **Yes** ☐ **No** ☐ **Nursing-** **Yes** ☐ **No** ☐

Planning Pregnancy? Yes ☐ **No** ☐ **Birth Control Pills?** **Yes** ☐ **No** ☐ **Irregular Periods - Yes** ☐ **No** ☐

CURRENT OR PAST HEALTH PROBLEMS - Review of Systems

AUTOIMMUNE DISEASE

Lupus **Yes** ☐ **No** ☐

LUNGS

Asthma **Yes** ☐ **No** ☐

Chronic Cough **Yes** ☐ **No** ☐

Tuberculosis **Yes** ☐ **No** ☐

CARDIOVASCULAR

Heart Attack **Yes** ☐ **No** ☐

High Blood Pressure **Yes** ☐ **No** ☐

Irregular heartbeat **Yes** ☐ **No** ☐

Defibrillator **Yes** ☐ **No** ☐

Artificial Valve **Yes** ☐ **No** ☐

Phlebitis/ Blood clot **Yes** ☐ **No** ☐

Pacemaker **Yes** ☐ **No** ☐

NEUROLOGICAL DISEASE

Epilepsy / Seizures **Yes** ☐ **No** ☐

Stroke **Yes** ☐ **No** ☐

JOINT DISEASE

Artificial Joints **Yes** ☐ **No** ☐

Arthritis **Yes** ☐ **No** ☐

GASTROINTESTIONAL

Hepatitis B or C **Yes** ☐ **No** ☐

Ulcers/ Reflux **Yes** ☐ **No** ☐

SKIN

Actinic Keratosis **Yes** ☐ **No** ☐

Skin Cancers **Yes** ☐ **No** ☐

Melanoma **Yes** ☐ **No** ☐

Eczema **Yes** ☐ **No** ☐

Psoriasis **Yes** ☐ **No** ☐

OTHER SYSTEMIC PROBLEMS

Diabetes **Yes** ☐ **No** ☐

Thyroid **Yes** ☐ **No** ☐

Kidney Problem **Yes** ☐ **No** ☐

Dialysis **Yes** ☐ **No** ☐

Cancer **Yes** ☐ **No** ☐

Cancer of ______________

Organ Transplant **Yes** ☐ **No** ☐

HIV / AIDS **Yes** ☐ **No** ☐

Depression **Yes** ☐ **No** ☐

List any illnesses you have? ____

FAMILY HISTORY - **MOTHER:** Age ______ Alive ☐ Deceased ☐ **FATHER:** Age ______ Alive ☐ Deceased ☐

CHILDREN: How Many _________ Ages___________ ___________ ___________ ___________ ___________

FAMILY MEDICAL CONDITIONS **(Mother, Father and blood relatives)** Melanoma **Yes** ☐ **No** ☐ Asthma **Yes** ☐ **No** ☐

Lupus: **Yes** ☐ **No** ☐ Arthritis: **Yes** ☐ **No** ☐ Diabetes: **Yes** ☐ **No** ☐ Eczema : **Yes** ☐ **No** ☐ **Other:** ________________

EMERGENCY CONTACT TO CALL: ________________________________ **PHONE:** _____________________

Patient Signature : _________________________________ Date ______________ Updated date ________________

Physician Signature: _________________________________ Date ______________ Updated date ________________