

Dermatology Medical History

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Skin:

Have you ever had skin cancer? Yes No

Has anyone in your family had skin cancer? Yes No

Do you have a history of any specific skin diseases? Yes No

Do you have problems with healing? Yes No

Do you develop keloid scars after surgery? Yes No

Do you bleed easily? Yes No

Have you ever had any of the following?:

blistering sunburns exposure to tanning beds eczema hay fever

Do you develop skin rashes in reaction to any of the following?:

medication food environment bandages Neosporin Other

If you checked yes to any of the above, please list below: _____

Social History:

Do you drink alcohol? Yes No

If yes, drinks per day/week

Do you smoke? Yes No

If yes, packs per day/week

Do you use IV drugs? Yes No

If yes, what? _____

Have you ever been exposed to HIV (AIDS)? Yes No

Women: Are you pregnant? Yes No

If yes, due date _____

Reason for today's visit: _____

Location: _____

Previous Therapy: _____

Duration: _____

Changes in size, color or shape: _____

Signs / Symptoms: _____

Prior history of problem: _____

Aggravating / Alleviating Factors: _____

Referred by: _____

Primary Care Provider: _____

Patient or Guardian Signature

Today's Date

