

Medical History Form

Date _____

Name _____ Phone _____

Address _____ DOB _____

Family Dr. _____ Referring Dr. _____

Age _____ Sex _____ Occupation _____

What is the nature of your skin problem? _____

Location _____ Duration _____ Onset _____

Drug Sensitivities or Allergies:

No Known Allergies

Aspirin Penicillin Novocaine Cortisone Iodine Latex

Tape Codeine Hayfever Sulfa

Others: _____

Medications:

Aspirin Coumadin Ibuprofen or Like

Other (Specify): _____

Past or Present Illnesses (Check all that apply)

- | | | |
|----------------------------------------------|------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Seizures | <input type="checkbox"/> Circulatory Problems |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke | <input type="checkbox"/> Nervous Disorder |

Other: _____

Do you have: Pacemaker Heart valve replacement Joint replacement

Family History

Melanoma Psoriasis

Other inherited skin disorders _____

Hospitalizations & Surgeries

Social

Tobacco Usage _____ Alcohol Usage _____

Dermatology

Doctor's Use

Exam Skin

Constitutional

- of three vital signs
- General appearance of patient

Eyes

- Conjunctivae and lids

Ears, Nose, Mouth & Throat

- Lips, teeth & gums
- Ompharynx

Neck

- Thyroid

Cardiovascular

- Peripheral vascular system (observation/palpitation)

Gastrointestinal

- Liver & spleen
- Anus (condyloma/other lesions)

Lymphatic

- Lymph nodes (neck, axillae, groin and/or other location)

Extremities

- Digits & nails

Skin

- Hair of scalp, eyebrows, face, chest, pubic area & extremities
- Head & neck
- Chest, breasts, & back
- Abdomen
- Genitalia
- Extremities
- Eccrine & apocrine glands of skin (hyperhidrosis, chromhidroses or bromhidrosis)

Neurological/Psychiatric

- Orientation to time, place & person
- Mood & affect

Total Visit Time: _____

Counseling Time: _____