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MEDICAL & COSMETIC DERMATOLOGY

Annual Medical History

NAME: _____ DOB: _____ DATE: _____

Currently Pregnant: ☐ Yes ☐ No Due Date: ___/___/___ Currently Breast Feeding: ☐ Yes ☐ No

Are you planning a pregnancy in the next year: ☐ Yes ☐ No

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list:_____

Have you ever had dental anesthesia (Lidocaine/Epinephrine)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

Healing Problems: ☐ YES ☐ NO

Natural/Original Hair Color: ☐ Black ☐ Brown ☐ Light Brown ☐ Blonde ☐ Red

Natural Eye Color: ☐ Black ☐ Brown ☐ Light Brown ☐Blue ☐ Hazel ☐ Gray ☐ Green ☐ Red

Skin Color: ☐ Very Pale ☐ Fair ☐ Med-Olive ☐ Dark ☐Olive Brown ☐ Brown ☐ Black

Past Medical History *Please place a check mark by any condition of which you may have had a history:*

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH (Benign Prostatic Hyperplasia)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis - Type: _____
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____
- ☐ NONE

Past Surgical History

- ☐ Appendix (Appendectomy)
- ☐ Breast : Lumpectomy
- ☐ Breast: Mastectomy
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart : Biological Valve Replacement
- ☐ Heart : Coronary Artery Bypass Surgery
- ☐ Heart : Mechanical Valve Replacement
- ☐ Heart : PTCA
- ☐ Joint Replacement: Hip Rt/Lt
- ☐ Joint Replacement : Knee Rt / Lt / Both
- ☐ Kidney : Kidney Stone Removal
- ☐ Ovaries (Oophorectomy)
- ☐ Prostate Cancer
- ☐ Uterus (Hysterectomy)
- ☐ Other: _____
- ☐ NONE

Skin Disease History

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma: Year _____
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Other: _____

Annual Medical History (continued)

Family History

□ Basal Cell □ Squamous Cell □ Melanoma □ Skin Cancer (unknown type) □ Acne □ Psoriasis □ Hair Loss □ Several Moles □ Skin Rashes □ High Blood Pressure

Which family member? _____

Please list any other significant family medical history:_____

_____

Medications: *List all medications you are currently taking: (or provide list)*

_____

Medication Allergies: _____

_____

Social History

- Drink alcohol? □ YES □ NO If YES _____ drinks per day
- Use recreational drugs? □ YES □ NO If YES, *what & how often*:_____
- Smoking Status**:** □Current everyday □Current some day's □Former □Never □Unknown if ever smoked

  Type: □Smokeless □Cigars □Cigarettes □Marijuana For how long:_____
- Do you use a tanning bed? □YES □NO Frequency:_____
- Do you tan outside? □YES □NO Frequency:_____
- Do you use sunscreen? □YES □ NO

Current Symptoms:

SKIN
Changing Moles → → □YES → □NO
Itching → → → □YES → □NO
Burning → → → □YES → □NO
Welts → → → □YES → □NO
Hives → → → □YES → □NO
Sores → → → □YES → □NO
CONSTITUTIONAL
Fever → → → □YES → □NO
Night sweats → → □YES → □NO
Chills → → → □YES → □NO
Weight changes → → □YES → □NO
CARDIAC
Chest pain → → □YES → □NO → → ¶
Irregular heart beat → □YES → □NO
EAR NOSE THROAT
Sores → → → □YES → □NO
Growths → → → □YES → □NO
Sinus Problems → → □YES → □NO
Difficulty Swallowing → □ Yes → □ No
GASTROINTESTINAL
Abdominal pain → → □YES → □NO
Diarrhea → → → □YES → □NO

GENTOURINARY
Abnormal Urination → □YES → □NO
Genital discharge → □YES → □NO
Menstrual irregularities → □YES → □NO
HEMATOLOGIC
Bruise easily → → □YES → □NO
Blood Clots → → □YES → □NO
MUSCULOSKELETAL
Joint pain → → □YES → □NO
Swelling → → □YES → □NO
Muscle pain/weakness → □YES → □NO
NEUROLOGIC
Weakness → → □YES → □NO
Numbness → → □YES → □NO
Headaches → → □ Yes → □ No
RESPIRATORY
Shortness of breath → □YES → □NO
Wheezing → → □YES → □NO
Cough → → → □YES → □NO
ENDOCRINE
Cold/Heat intolerance → □YES → □NO
OTHER: _____