Academic Dermatology of Nevada
The smart approach to skin disorders.

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Name: _____

Medical History Form

Date of Visit: _____ **Date of Birth:** _____ **Age:** _____ **Gender: M F**

Reason for dermatology visit? _____

Medical Conditions

☐ **None OR Write "P" for Past and "C" for Current Problem (Use other* if problem not listed).**

____ Gout
____ Osteoarthritis
____ Rheumatoid Arthritis
____ Osteoporosis
____ Scoliosis
____ Fracture / Broken Bone
____ Cerebral Palsy
____ Dementia
____ Neuropathy
____ Seizure Disorder

____ Heart Disease
____ High Blood Pressure
____ High Cholesterol
____ Stroke
____ Blood Clots / DVT
____ Pulmonary Embolism
____ Asthma
____ Chronic Bronchitis
____ COPD
____ Anemia

____ Bleeding Disorder
____ Sickle Cell Trait / Disease
____ Diabetes
____ Thyroid Disorder
____ Liver Disease
____ Hepatitis
____ Ulcers / Reflux
____ Kidney Disease
____ Pregnant
____ Breastfeeding

____ Cancer Hx (history):
Type: _____

Psychological Disorders:
____ Depression
____ Drug Abuse
____ Alcohol Abuse
Other: _____
____ HIV / AIDS
____ Hx Hepatitis: A B C
Other: _____

List Drug Allergies & Reactions	**Current Medications,** **None:** ☐		**List Past Surgery & Dates,** **None:** ☐

☐ **None**

Family History

☐ **Unknown/Adopted OR indicate if any of your blood relatives have had any of the following conditions**

____ Skin Cancer
____ Melanoma
____ Hay Fever / Allergy
____ Atopic Dermatitis
____ Psoriasis

____ Eczema
____ Rheumatoid Arthritis
____ Osteoporosis
____ Muscle Disorders
____ Heart Disease

____ High Blood Pressure
____ Respiratory Disease
____ Blood Disease
____ Bleeding Disorder
____ Diabetes

____ Kidney Disease
____ Depression
____ Cancer:
Type: _____
Other: _____

Social History

Tobacco Use: **Non Smoker:** ☐	**Alcohol Use:** **Never:** ☐	**Marital Status:** **Other:**
____ Former Smoker	____ Rarely	____ Single _____
Year Quit _____	____ Weekly	____ Married _____
____ Current smoker, # Pack/day _____	____ Daily	____ Divorced
# Years _____	How much daily: _____	____ Widowed

Do you have an advance directive? ……no yes
Are you a victim of violence or abuse? ……...no yes
Have you had a flu shot this year? ……..…..no yes
Have you had a pneumonia shot? ……no yes
Have you been hospitalized for any reason? ……....no yes

Name of Primary Care Provider if applicable: _____