



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).

<input type="checkbox"/> Gout	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Cancer Hx (history): Type: _____
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sickle Cell Trait / Disease	Psychological Disorders:
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Depression
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Blood Clots / DVT	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> Fracture / Broken Bone	<input type="checkbox"/> Pulmonary Embolism	<input type="checkbox"/> Hepatitis	Other: _____
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ulcers / Reflux	<input type="checkbox"/> HIV / AIDS
<input type="checkbox"/> Dementia	<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Hx Hepatitis: A B C
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> COPD	<input type="checkbox"/> Pregnant	Other: _____
<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Anemia	<input type="checkbox"/> Breastfeeding	

List Drug Allergies & Reactions	Current Medications, None: <input type="checkbox"/>	List Past Surgery & Dates, None: <input type="checkbox"/>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

None **Family History**

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

<input type="checkbox"/> Skin Cancer	<input type="checkbox"/> Eczema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Melanoma	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Hay Fever / Allergy	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Cancer: Type: _____
<input type="checkbox"/> Atopic Dermatitis	<input type="checkbox"/> Muscle Disorders	<input type="checkbox"/> Bleeding Disorder	Other: _____
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	

Social History

Tobacco Use:	Non Smoker: <input type="checkbox"/>	Alcohol Use:	Never: <input type="checkbox"/>	Marital Status:	Other:
<input type="checkbox"/> Former Smoker		<input type="checkbox"/> Rarely		<input type="checkbox"/> Single	_____
<input type="checkbox"/> Year Quit _____		<input type="checkbox"/> Weekly		<input type="checkbox"/> Married	_____
<input type="checkbox"/> Current smoker, # Pack/day _____		<input type="checkbox"/> Daily		<input type="checkbox"/> Divorced	_____
<input type="checkbox"/> # Years _____		<input type="checkbox"/> How much daily: _____		<input type="checkbox"/> 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: _____