Dermatology Medical History

Name: _____ Date of Birth:___/___/____ Date:__/___/____

E-mail address:_____

Primary Care Doctor: _____

MEDICINES you are taking (prescription, over-the-counter, supplements, vitamins):1) _____

2) _____ 3) _____ 4) _____

5) _____6) _____ 7) _____

for additional, check here ☐ & continue on back

MEDICATION ALLERGIES: (☐ None) _____

Have you ever had a reaction to local anesthesia (like dental anesthesia, novocaine, etc.)? ☐ Yes ☐ No
If yes, please describe the reaction:_____

MEDICAL CONDITIONS: Do you have diseases or conditions of any of the below? (Please check YES or NO)

Lungs:	Yes	No	Other systemic conditions:	Yes	No
Bronchitis	☐	☐	Diabetes	☐	☐
Emphysema	☐	☐	Thyroid	☐	☐
Asthma	☐	☐	Kidney	☐	☐
Chronic cough	☐	☐	Dialysis	☐	☐
Shortness of breath	☐	☐	Liver:		
Wheezing	☐	☐	hepatitis	☐	☐
Cardiovascular:			cirrhosis	☐	☐
High blood pressure	☐	☐	Arthritis/Joint pain	☐	☐
Chest pain	☐	☐	Artificial joint	☐	☐ (If yes, please specify
Stroke	☐	☐	which is/are affected) _____		
History of heart attack	☐	☐	Gastrointestinal (Crohn's,		
Irregular heartbeat	☐	☐	ulcerative colitis, celiac)	☐	☐
Blood clot	☐	☐	Convulsions, epilepsy, seizures	☐	☐
Pacemaker/defibrillator	☐	☐	Fainting	☐	☐
Easy bruising	☐	☐	Other:_____		

Skin:

Have you ever had skin cancer? ☐ Yes ☐ No If yes, what type(s)? ☐ melanoma ☐ squamous cell ☐ basal cell

☐ unsure ☐ other: _____ If yes, indicate type, location & method of treatment of most recent skin cancer: _____

Year of treatment _____

Has any of your family had skin cancer? ☐ Yes ☐ No If yes, who and what kind?_____

Have you been diagnosed with a skin disease? ☐ Yes ☐ No If yes, what kind?_____

Skin Health Dermatology, PLLC

611 W. State Hwy 6 Ste. 115, Waco, TX 76710-7545
Phone: (254)265-7546 Fax: (254) 265-7542

Does your skin heal with thick, raised scars (keloids) after injuries or surgeries? ☐ Yes ☐ No

Have you had any surgeries? ☐ Yes ☐ No If yes, please specify: _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____
How much do you smoke? _____ ☐ I don't smoke
(For females)Are you pregnant?☐ Yes ☐ No If yes, when is your due date? ____/_____/_____
Breastfeeding? ☐ Yes ☐ No

What is your occupation?_____ Hobbies: _____

Reason for today's visit:_____

Patient signature _____ Date signed: ___/____/_____

Reviewed by _____ Date: ___/____/_____

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