

The Art and Science of Dermatology

HISTORY FORM

Date of Visit: _____

Allergies: _____

Name: _____

Age: _____ DOB: _____ Sex: _____

Race: _____

For nurse only:

Sent at request of: _____

Estab Pt _____ New Pt _____

#1 **Most Important** reason for visit today: _____

Body site(s) involved: _____

How long has this been a problem? _____

Any and all treatments, Past: _____

Present: _____

Treatment(s) that helped: _____

Other Symptoms (itching, pain, burning, other): _____

List **ALL MEDICATIONS** below you are currently taking on a regular or as-needed basis. Include prescription, over-the-counter meds, vitamins, herbals, and topical medications:

Dermatology Specific Questions:

	Yes	No	If "Yes" provide details:		
Have you ever had skin cancer?	Yes	No	_____	_____	_____
Have you ever been <u>diagnosed</u> with dysplastic nevi (abnormal moles)?	Yes	No	_____	_____	_____
Has anyone in your family had skin cancer?	Yes	No	_____	_____	_____
Has anyone in your family been <u>diagnosed</u> with dysplastic nevi (abnormal moles)?	Yes	No	_____	_____	_____
Do you have a history of any other skin disease?	Yes	No	_____	_____	_____
Do you have a problem with healing?	Yes	No	_____	_____	_____
Do you develop keloids after surgery or trauma?	Yes	No	_____	_____	_____
Have you <u>ever</u> had a fever blister?	Yes	No	_____	_____	_____
Do you bleed easily?	Yes	No	_____	_____	_____
Do you develop skin rashes in reaction to:	Medications	Food	Environment	Bandages	
Topical Neosporin					
Other	_____	_____	_____	_____	_____

Please check your skin type:

Very fair, always burns, never tans	Medium, sometimes burns, always tans	Brown, never burns, always tans	
Fair, always burns, sometimes tans	Olive/light brown, rarely burns, always tans	Dark brown or black, never burns, always tans	
If "Yes" provide details:			
Have you had bad sunburns?	Yes	No	_____
Skin blistering?	Yes	No	_____
☺Sun poisoning☺/rash from sun?	Yes	No	_____
Do you use sunscreen daily?	Yes	No	If yes, what SPF rating? _____

Women:

Are you pregnant? Yes No If yes, how many weeks? # _____
 Are you breastfeeding? Yes No Have you recently delivered? Yes No
 Are you actively trying to get pregnant? Yes No If yes, how many months postpartum? # _____
 Are you soon to be trying to get pregnant? Yes No

Review of Systems: Please check the problems you have had in the last few weeks or currently have.

<input type="checkbox"/> Fever	<input type="checkbox"/> Watery, Itchy Eyes	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Joint Pain/Stiffness
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Swelling in Legs	<input type="checkbox"/> Swelling of Joints
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Swelling Around Eyes	<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Leg pain when Walking	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Fatigue		<input type="checkbox"/> Kidney Stones		<input type="checkbox"/> Muscle Pain
<input type="checkbox"/> Allergies	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Headaches	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Hives	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Fainting or blackouts	<input type="checkbox"/> Depression
<input type="checkbox"/> Itching	<input type="checkbox"/> Ulcers in Mouth	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Runny Nose	<input type="checkbox"/> Hearing Loss		<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Confusion
	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Easily Bruise/Bleed	<input type="checkbox"/> Nausea/Vomiting	
	<input type="checkbox"/> Heat or Cold Intolerance	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Diarrhea	
	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Abdominal Pain	
	<input type="checkbox"/> Excessive Urination		<input type="checkbox"/> Indigestion/Reflux	

For any areas checked above please provide details:

Past Medical History: Please check the problems you have or have had in the past. (Items checked please explain)

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Birth defects/Handicaps |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Other Lung Disease | <input type="checkbox"/> Gastrointestinal Disorder. What? _____ |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Stroke / TIAs (mini stroke) |
| <input type="checkbox"/> Other Heart Disease | <input type="checkbox"/> Cold Sore/Herpes | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Psychiatric Condition. What? _____ |
| <input type="checkbox"/> Inflammation of Vein (s) | <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Other Vascular Disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Raynauds | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Other Auto-Immune Disorders | <input type="checkbox"/> Cancer ó where/type _____ |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Bronchitis (acute or chronic) | <input type="checkbox"/> Eczema | |
| <input type="checkbox"/> Emphysema | | |

If you have other conditions or problems not listed above, please explain: _____

Please list prior surgeries or upcoming planned surgeries or procedures: _____

Social History:

Do you drink alcohol? Yes No If yes, _____drinks per day? _____ per week?
 Do you or have you ever smoked cigarettes? Yes No If yes, how much? _____ date quit? _____
 Any history of IV drug use? Yes No If yes, explain: _____
 What is your occupation? _____
 Hobbies? _____

Completed by: Patient/Parent/Guardian _____ /_____/_____
 Staff Member _____ Signed by patient&/or guardian Date of Visit
 (initials) _____
 Reviewed by Provider _____ Date