

Bay Area Dermatology Medical History Form

PATIENT INFORMATION

NAME _____ AGE _____ Male Female
 OCCUPATION _____ HOBBIES _____

Do you live alone? Yes No Do you smoke? Yes No Smoked in the Past? Yes No
 Do you drink alcohol? Yes No How much? _____ Recreational Drug Use? Yes No

List current prescription medications _____

List any "Over the Counter Medications" _____

Pharmacy Used _____ Pharmacy Phone _____

Do you take Aspirin? Yes No Blood Thinners? Yes No

Any ALLERGIES to Medications ? Yes No Yes, List _____

Have you had an Allergic Reaction to local anesthetics? Yes No Latex Yes No

FEMALES ONLY Are you pregnant? Yes No Nursing- Yes No

Planning Pregnancy? Yes No Birth Control Pills? Yes No Irregular Periods - Yes No

CURRENT OR PAST HEALTH PROBLEMS - Review of Systems

AUTOIMMUNE DISEASE

Lupus Yes No

LUNGS

Asthma Yes No

Chronic Cough Yes No

Tuberculosis Yes No

CARDIOVASCULAR

Heart Attack Yes No

High Blood Pressure Yes No

Irregular heartbeat Yes No

Defibrillator Yes No

Artificial Valve Yes No

Phlebitis/ Blood clot Yes No

Pacemaker Yes No

NEUROLOGICAL DISEASE

Epilepsy / Seizures Yes No

Stroke Yes No

JOINT DISEASE

Artificial Joints Yes No

Arthritis Yes No

GASTROINTESTINAL

Hepatitis B or C Yes No

Ulcers/ Reflux Yes No

SKIN

Actinic Keratosis Yes No

Skin Cancers Yes No

Melanoma Yes No

Eczema Yes No

Psoriasis Yes No

OTHER SYSTEMIC PROBLEMS

Diabetes Yes No

Thyroid Yes No

Kidney Problem Yes No

Dialysis Yes No

Cancer Yes No

Cancer of _____

Organ Transplant Yes No

HIV / AIDS Yes No

Depression Yes No

List any illnesses you have? _____

FAMILY HISTORY - MOTHER: Age _____ Alive Deceased **FATHER:** Age _____ Alive Deceased

CHILDREN: How Many _____ Ages _____

FAMILY MEDICAL CONDITIONS (Mother, Father and blood relatives) Melanoma Yes No Asthma Yes No

Lupus: Yes No Arthritis: Yes No Diabetes: Yes No Eczema : Yes No Other: _____

EMERGENCY CONTACT TO CALL: _____ **PHONE:** _____

Patient Signature : _____ Date _____ Updated date _____

Physician Signature: _____ Date _____ Updated date _____