Hartsough Dermatology

Medical History Form

Patient Name:____ Today's Date: ____________________

Date of Birth_______________ Age____

Reason for today's visit:____

How long have you had this problem? _____________ Affected Locations _________________________

Past Medical History – Do you have now, or have you ever had diseases or conditions of:

Cardiovascular	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Coronary Heart Disease	☐	☐	Inflammation of veins	☐	☐	Chest Pain	☐	☐
Blood Clots	☐	☐	Pace Maker	☐	☐	Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐	High Blood Pressure	☐	☐			

Lungs	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Bronchitis	☐	☐	Emphysema	☐	☐	Asthma	☐	☐
Chronic Morning Cough	☐	☐	TB (tuberculosis)	☐	☐			

Endocrinology	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Recent Hair Loss	☐	☐	Thyroid Disease	☐	☐	Diabetes	☐	☐
Recent weight loss or gain	☐	☐						

Other	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Gastrointestinal Problems	☐	☐	Kidney Disease	☐	☐	Dialysis	☐	☐
Arthritis/Joint Problems	☐	☐	Blood Diatheses	☐	☐	Anemia	☐	☐
Hepatitis	☐	☐	Aids Risk	☐	☐	Fainting	☐	☐

Cancer: **Yes** ☐ **No** ☐ If yes, type____________________ Date ___________________

Has anyone in your family had skin cancer? **Yes** ☐ **No** ☐

If yes, what type: _______________________and who, ____

List any other diseases or conditions:____

List any surgical procedures for the last 2 years: ____

Skin

When you are exposed to the sun do you: Tan, never burn ☐ Tan more than burn ☐

Burn more than Tan ☐ Burn never tan ☐

Do you have a history of specific skin disease? **Yes** ☐ **No** ☐

If yes, please list ____

Do you develop Keloids (large scars) after injury to the skin? **Yes** ☐ **No** ☐

Do you bleed/bruise easily? **Yes** ☐ **No** ☐

Do you have problem with poor wound healing? **Yes** ☐ **No** ☐

Have you ever had dental or local anesthesia? **Yes** ☐ **No** ☐

Have you had any negative reaction to anesthesia? **Yes** ☐ **No** ☐

If yes, what was the reaction? ____________________________

Social History

Do you use tobacco? **Yes** ☐ **No** ☐ If yes how much per day? ______________________

Drink Alcohol? **Yes** ☐ **No** ☐ If yes how many per day? ______________________

Do you use street drugs? **Yes** ☐ **No** ☐ If yes what? _________________ How often? _____

Have you been exposed to HIV (Aids)? **Yes** ☐ **No** ☐

Women

Are you pregnant or nursing? **Yes** ☐ **No** ☐ Due Date: ___________

Type of Birth Control ______________

Completed By: Patient ☐ Medical Assistant ☐ ______

Signature of Patient, Parent or Guardian: __________________________________ Date ____________

Reviewed By:____ Date _______________