SOUTHSIDE DERMATOLOGY & LASER COSMETIC CENTER

Dermatology Medical History

Referring Physician : _____

What is the reason for your visit? _____

How long have you had this condition? _____

Where is it located: _____

What have you used to treat this condition? _____

What makes it worse or better? _____

Pharmacy Information:

Pharmacy Name	**Zip Code**	**Address**	**Phone Number**
_____	_____	_____	_____

Patient Allergies (if none, please write none)

Allergy	**Reaction**	**Notes**
1. _____	_____	_____

Patient Current Medications (if none, please write none)

Drug	**Dosage**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Review of Systems/Patient Medical History (Answer is assumed negative unless box is checked).

SKIN	**No**	**Yes**	**Details**
Skin Cancer (type and location)			
Other Cancers (please list)			
Abnormal Moles			
Melanoma			
Herpes simple (cold sores)			
Eczema			
Sensitive skin			
Hives			
Connective Tissue Disease			
Psoriasis			
Lupus			
Sarcoid			
Keloids/Raised Scars			
Cystic Acne			
Accutane (isotretinoin)used within past 6 months			
Excessive sweating			
Heart Murmur			
Gold Therapy			
Radiation Exposure			

Review of Systems/Patient Medical History (Answer is assumed negative unless box is checked).

SKIN	No	Yes	Details
Warts			
Vitiligo			
Raynauds's Disease			
Other Skin Disease (specify):			
CONSTITUTIONAL			
Weight loss (unintentional)			
Hair Loss			
Nutritional deficiencies (specify):			
PSYCHIATRIC			
Depression			
Stress			
Anxiety			
Other (specify):			
INFECTIOUS			
Herpes			
HIV/AIDS			
Hepatitis (what type?)			
Yeast infection when taking antibiotics			
Other infectious disease (please list)			
HEMATOLOGIC/LYMPHATIC			
Bruises easily			
Blood transfusions			
Blood clots			
Anemia			
Enlarged lymph nodes			
ENDOCRINE			
Diabetes			
Thyroid disease			
Excessive hair, face/body			
CARDIOVASCULAR			
High Blood Pressure			
Pacemaker			
Stroke			
Heart Surgery			
Heart valve replacement			
Rheumatic fever			
Leg edema (swelling)			
Shortness of breath			
Heart disease (specify):			
RENAL/GENITOURINARY			
Kidney disease/stones			
Incontinence			
Urgency			
Discharge			
Blood in urine			
Painful urination			
Genital sores/ulcers			

RESPIRATORY			
Asthma/Allergies/Hayfever			
Tuberculosis			
Bronchitis (chronic)			
Cough (chronic)			
Lung disease (specify):			
NEUROLOGICAL			
Seizures			
Migraine			
Headaches			
Neurological disorder (specify)			
MUSCULOSKELETAL/RHEUMATOLOGY			
Artificial Joints			
Arthritis			
Fibromyalgia			
Joint swelling			
Cold hands and feet			
Musculoskeletal Disorder (specify):			
HEPATIC/GASTROINTESTINAL			
Ulcer			
Diarhea			
Nausea/Vomiting			
Chrohn's Disease			
Ulcerative Colitis			
Inflammatory Bowel Disease			
Liver Disease (specify):			
EYES, EARS, NOSE, THROAT			
Wear Hearing Aids			
Wear Contact Lenses			
Glaucoma			
Hearing difficulty			
Sinusitis			
Dizziess			
Oral Ulcers			
Conjunctivitis			
Chills/Fever			
Chest Pain			
Defibrillator			
Loss of vision			
Double vision			
Abdominal Pain			

OB/GYN History, if relevant (Answer is assumed negative unless box is checked)

	NO	**YES**	**Details**
Pregnancies			
Currently Pregnant			
Miscarriages			
Nursing			
Irregular Menses			
Birth Control Pills			

SKIN CANCER HISTORY

	Date	Location	Type	Treatment
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Surgeries/Hospitalizations (if none, please write none)

Surgery/Hospitalization	Date	Anesthesia Complications	Notes
1.			
2.			
3.			
4.			
5.			

Patient Family History (answer is assumed negative unless box is checked)

	No	Yes	Notes
Melanoma			
Other Skin Cancer (please list)			
Other Cancers (please list)			
Skin Disease (please list)			
Abnormal Bleeding/Clotting			
Eczema/Asthma/Allergies			
Autoimmune Disorders			
Psoriasis			
Endocrine Disease			
Other (please list)			

Occupation: _____

Hobbies: _____

Patient Social History

ALCOHOL

□ denies alcohol use

□ admits alcohol use socially

□ admits alcohol use daily

STD

□ denies STD history

□ admits STD history

ILLEGAL DRUGS

□ denies using illegal drugs

□ admits to using illegal drugs

Patient Smoking History

□ denies tobacco use

_____ packs per day

MEDICAL HISTORY VERIFICATION

All information provided above is accurate and complete to the best of my knowledge.

_____ _____ _____

Printed Patient Name | Patient Signature | Date