

PATIENT HISTORY

Name _____ DOB _____ Date _____

Reason for today's visit: _____

Duration of the condition: _____

Past Medications Used for this Condition:

Allergies:

_____ Adhesive Tape
_____ Latex
_____ Lidocaine/Novacaine
_____ Nickel
_____ Perfume
_____ Poison Ivy
_____ Sunlight

List Allergies to Medications:

Current Medications:

Past Medical History:

_____ Any Dermatologic Problems
_____ Arthritis Conditions
_____ Asthma
_____ Cardiac Diseases
_____ Diabetes
_____ Eczema
_____ Hypertension
_____ Lipid Disorders
_____ Musculoskeletal Problems
_____ Skin Cancer
_____ Thyroid Disorder
_____ Cancer
_____ Pacemaker/Implanted device
_____ Other

Family History:

_____ Any Dermatologic Problems
_____ Skin cancer

Social History:

_____ Do you drink Alcohol?
_____ If yes, how often?
_____ Do you Smoke?

Female Patients Only:

Are you pregnant? Yes or No
Are you breast feeding? Yes or No