



DERMATOLOGIST MEDICAL GROUP OF NORTH COUNTY, INC.
PATIENT MEDICAL HISTORY

Date _____

Name of Patient: _____

Date of Birth ___/___/___

Reason for visit _____

Are you allergic to any medication or topical creams? No ___ Yes ___
if yes, list:

List medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

List all medical conditions or diagnoses

List any surgeries you have had and dates

Do you have or have ever had diseases or conditions of: (please circle YES or NO)

Table with 10 columns: Condition, No, Yes, Condition, No, Yes, Condition, No, Yes. Rows include: High blood pressure, Chest pain, Heart attack, Heart murmur, Irregular heart beat, Blood clot, Phlebitis, Non-skin cancer, Eye condition, Ear condition, Thyroid problem, Kidney problem, Bladder problem, Stomach problem, Digestion problem, Eczema, Diabetes, Emphysema, Asthma, Shortness of breath, Autoimmune disease, Excess fatigue, Unexplained fever, Arthritis, Seizures, Headache/migraine, Stroke, Neurological problem, Fainting, Dizziness.

Please answer the following questions related to your skin:

Have you ever had skin cancer? No Yes
If yes, please list type (basal cell carcinoma, squamous cell carcinoma, Melanoma, other), location, approximate dates _____

Has any one in your family had skin cancer? No Yes
If yes which type – BCCA / SCCA / Melanoma / other (please circle)

Do you have any history of skin diseases? No Yes
If yes, please list _____

Have you had any skin procedures performed – liquid nitrogen, biopsies, cosmetic procedures? - list _____

Do you have a history of atypical or Dysplastic moles? No Yes
Is there a family history of atypical or Dysplastic moles? No Yes
Have you ever had blistering sunburn? No Yes
Do you wear sunscreen? No Yes

If yes do you wear sunscreen – daily / not every day (please circle) – what SPF _____
Do you wear a hat? No Yes
Do you wear sunglasses? No Yes
When you are exposed to the sun, do you? Tan ____ Tan and burn ____ Burn ____

Where did you grow up? _____

Please answer the following questions:

Do you bleed or bruise easily? No Yes
Do you have problems with healing? No Yes
Do you have problems with excessive scarring or keloids? No Yes

Do you take blood thinners? No Yes
Do you take any supplements containing vitamin E other than a multivitamin? No Yes
Do you take aspirin products or anti-inflammatory medicines? No Yes
Do you take antibiotics prior to surgery or dental procedures? No Yes

If yes, why _____
Do you have artificial joint(s) or heart valve(s)? No Yes

If yes, what is the date? _____ valve or joint? _____
Do you have a Pacemaker? No Yes
Do you have a Defibrillator? No Yes
Have you ever had any bad reaction to anesthesia? No Yes

Is there a family history of diabetes? No Yes
Is there a family history of autoimmune disease? No Yes
Is there a family history of thyroid problem? No Yes
Is there a family history of eczema? No Yes
Is there a family history of cancer? No Yes

Do you drink alcohol? No Yes If yes, drinks per day _____
Do you smoke or have you ever smoked? No Yes

if yes, how much _____ if quite, what year _____
Have you ever used IV drugs? No Yes If yes, what _____

Have you had or have you ever been exposed to HIV (AIDS)? No Yes
Have you had or have you ever been exposed to hepatitis B or C? No Yes
Have you had or ever been exposed to Tuberculosis, or have a positive TB test? No Yes

For Women:

Are you pregnant? No Yes If yes, Due Date: _____
Are you trying to become pregnant? No Yes
Are you nursing your baby? No Yes

Signature of patient or guardian _____ Date _____