Avenues Dermatology

Dermatology Medical History

Patient: _____ Date: _____

Reason for today's Visit: _____

Are you allergic to any medications? □Yes □No Any bad reaction? □Yes □No

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

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had, diseases or conditions of: (Please check Yes or No)

Lungs:

Bronchitis	□Yes □No
Emphysema	□Yes □No
Asthma	□Yes □No
Chronic Cough	□Yes □No
Morning Cough	□Yes □No
Shortness of Breath	□Yes □No
Wheezing	□Yes □No

Cardiovascular:

High Blood Pressure	□Yes □No
Chest Pain	□Yes □No
Heart Attack	□Yes □No
Heart Murmur	□Yes □No
Irregular Heartbeat	□Yes □No
Phlebitis	□Yes □No
Inflammation of the vein	□Yes □No
Blood Clots	□Yes □No
Pacemaker	□Yes □No
Stroke	□Yes □No

Other Systemic:

Diabetes	□Yes □No
Excessive thirst/hunger	□Yes □No
Amputation	□Yes □No
Thyroid	□Yes □No
Kidney	□Yes □No
Dialysis	□Yes □No
Bladder	□Yes □No
Frequency/Burning	□Yes □No

Gastrointestinal:

Stomach absorptive disorder	□Yes □No
Nausea, vomiting, diarrhea when taking antibiotics	□Yes □No
Yeast infection w/antibiotics	□Yes □No
Arthritis/Joint Deformity:	□Yes □No
Arthralgia	□Yes □No
Limited Motion	□Yes □No
Artificial Joint	□Yes □No
Convulsions, Epilepsy or Seizures	□Yes □No
Fainting	□Yes □No

List any other diseases or conditions: _____

List any surgical procedures you have had: _____

Skin:

Have you ever had skin cancer?	□Yes □No	
Has anyone in your family had skin cancer?	□Yes □No	
Do you have a history of any specific skin disease?	□Yes □No	If yes, _____
Do you have problems with healing?	□Yes □No	
Do you develop keloids (scars) after surgery?	□Yes □No	
Do you bleed easily?	□Yes □No	

Do you develop skin rashes in reaction to: □Medications □Food □Environment □Bandages □Topical Neosporin □Other _____

Social History:

Do you drink alcohol?	□Yes □No	If YES, how many drinks per day? _____
Do you use IV drugs?	□Yes □No	If YES, what & how often? _____
Do you smoke?	□Yes □No	If YES, how much? _____
Have you had or have you been exposed to HIV (AIDS)?	□Yes □No	
(Women) Are you pregnant?	□Yes □No	If YES, Due Date: _____/_____/_____

What is your occupation? _____ Hobbies? _____

Completed by: □Patient □Medical Assistant □Other

Patient's Signature: _____ Date: _____

Reviewer's Signature: _____ Date: _____