

# Patient Health History

# DUNDEEDERMATOLOGY

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Family Doctor \_\_\_\_\_

Do you have any allergies to medications, foods, latex, or ANY other substance?  **yes**  **no** if yes, list below:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_

List all current medication: (include medicated skin creams, vitamins, & herbal or natural supplements)

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ City/ Location \_\_\_\_\_

## Medical Surgical History (please mark all that apply)

- Skin Disease**
- Acne
  - Eczema
  - Melanoma
  - Other Skin Cancer
  - Psoriasis
  - Warts
  - Keloid Scars
  - Atypical Moles

- Endocrine Disease**
- Diabetes
  - Thyroid

- Heart Disease**
- Chest Pain
  - Heart Murmur
  - High Blood Pressure
  - Mitral Valve Prolapse
  - Pacemaker
  - Rheumatic Fever

- Infections**
- HIV+
  - Hepatitis
  - Tuberculosis

- Lung Disease**
- Asthma/ Hay Fever
  - Emphysema
  - Hay Fever
  - Sarcoid
  - Shortness of Breath
  - Wheezing
  - Cough

- For Women**
- Breast Feeding
  - Pregnant
  - Hysterectomy
  - Irregular Menses
  - Menopause
  - Attempting Pregnancy

- For Children**
- Premature Birth
  - Genetic Disorder

- Other Conditions**
- Arthritis
  - Bleeding Disorder
  - Cancer/ Lymphoma
  - Clotting Disorder
  - Colon Disease
  - Gout
  - Kidney Disease
  - Liver Disease
  - Loss of Consciousness
  - Lupus
  - Muscle Weakness
  - Neurologic Disease
  - Anxiety/ Depression
  - Seizures
  - Stomach Ulcers/ Reflux
  - Urinary Problems
  - Varicose Veins
  - Leg Swelling
  - Eye Problems
  - Cancer
  - Organ Transplant

- Surgical History**
- Artificial Joint
  - Heart Valve Surgery
  - Skin Cancer Surgery
  - Recent Surgery last 90 days

- Family History**
- Cystic, Scarring Acne
  - Eczema
  - Psoriasis
  - Skin Cancer

List All Major Surgeries	Year
_____	_____
_____	_____
_____	_____

**Other Medical History, explain positive marked items**

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## Social History

- Occupation \_\_\_\_\_
- Marital Status  Single  Married  Divorced  Widowed
- Do you smoke?  No  Yes Packs per Day \_\_\_\_\_
- Do you drink alcohol?  No  Yes Drinks/Week \_\_\_\_\_

physician reviewed \_\_\_\_\_ MD \_\_\_\_\_ date updated: (initials/date): \_\_\_\_\_