MEDICAL HISTORY

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age:_____

Reason for visit: _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, list: Latex Allergy?_____

1. _____ 2. _____

List all medications (incl. herbals/supplements) you are currently taking:

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

GENERAL MEDICAL: Do you have now, or have you ever had?:

	Yes	No		Yes	No		Yes	No
Asthma	☐	☐	Seizures	☐	☐	Arthritis	☐	☐
Seasonal allergies	☐	☐	Depression	☐	☐	Ulcers	☐	☐
High Blood Pressure	☐	☐	Thyroid	☐	☐	Fever blisters	☐	☐
Heart Attack	☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐
Phlebitis	☐	☐	Glaucoma	☐	☐	Cancer	☐	☐
Blood clots	☐	☐	Cataracts	☐	☐	Hives	☐	☐
Miscarriages	☐	☐	Lupus	☐	☐			

	Yes	No		Yes	No
Do you smoke cigarettes?	☐	☐	Do you have artificial joints/heart valves?	☐	☐
Have you been exposed to HIV/AIDS?	☐	☐	Do you take blood thinners daily?	☐	☐
Do you have a pacemaker/defibrillator?	☐	☐			

List any other conditions we should know about: _____

Did you have any surgical/dental procedures in the last 6 months?_____

Do you have a family history of autoimmune disorders, acne, eczema, or psoriasis? (who/what?)

_____

SKIN:

Have you ever visited a dermatologist? ☐Yes ☐No Who? _____ When? _____

Reason/Therapy? _____

When you are exposed to the sun do you: ☐Tan only ☐Burn then tan ☐Burn

Do you actively seek a tan ('laying out' or tanning bed)?	☐Yes	☐No	
Do you regularly use sunscreen?	☐Yes	☐No	
Have you ever had skin cancer?	☐Yes	☐No	What kind? _____
Have you ever had abnormal moles removed?	☐Yes	☐No	Details:_____
Blistering sunburns?	☐Yes	☐No	
Has anyone in your family had skin cancer?	☐Yes	☐No	If yes, who? _____
Do you form keloids (thick scars)?	☐Yes	☐No	
Have you had cosmetic procedures?	☐Yes	☐No	_____

Were you happy with the results? Explain: _____

Anything else you would like us to know?_____

Signature of Patient/Guardian: _____ Date: _____

STAFF USE ONLY:

Review Date: _____ Review Date: _____ Review Date: _____ Review Date: _____
Review Date: _____ Review Date: _____ Review Date: _____ Review Date: _____

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Midlothian Dermatology 2306 Robious Station Circle Midlothian, VA 23113 804 378-3048