FAYETTE AREA DERMATOLOGY

Medical History

Name _____ Age _____ Date _____

Reason for today's visit: (chief complaint)

_____

_____

Medical History

Have you had problems with any of the following? (Check all that apply)

	No	Current	Past	Please Explain
General Health	☐	☐	☐	_____
Eyes	☐	☐	☐	_____
Ears/Nose/Throat/Mouth	☐	☐	☐	_____
Heart	☐	☐	☐	_____
Lungs	☐	☐	☐	_____
Stomach/Bowel	☐	☐	☐	_____
Kidney/Bladder	☐	☐	☐	_____
Arthritis/Muscles	☐	☐	☐	_____
Skin	☐	☐	☐	_____
Headaches/Seizures	☐	☐	☐	_____
Psychological	☐	☐	☐	_____
Thyroid/Diabetes	☐	☐	☐	_____
Blood	☐	☐	☐	_____
Allergic/Immunologic	☐	☐	☐	_____

Females only: ___ Currently Pregnant ___ Abnormal Periods ___ Yeast Infections
___ Planning Pregnancy ___ On Birth Control ___ Breast Feeding

Do you take blood thinner or aspirin? ___Yes ___No

Cancer(s): (List Type, Date, Treatment)

_____

Current Medications

_____
_____
_____

Medication Allergies (circle)

NONE Sulfur Penicillin Lidocaine
Codeine Tetracycline Band-aids
Others: _____

Family History

Check the following medical conditions that have occurred in your family

	Mother	Father	Blood Relative
Allergies	☐	☐	☐
Asthma	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Eczema	☐	☐	☐
Hay Fever	☐	☐	☐
Melanoma	☐	☐	☐
Psoriasis	☐	☐	☐
Other Skin Problem	☐	☐	☐

Social History

Do you live alone? ___No ___ Yes
Do you drink alcohol? ___No ___Yes-amount? _____
Occupation: _____
How much time do you spend in the sun? _____

Do you smoke? ___No ___Yes-frequency? ___ _____
Do you use recreational drugs? ___No ___Yes-frequency? ____
Hobbies/leisure activities: _____
Tanning bed? _____

MA Initials: _____ Date: _____

Date Reviewed: _____ Date: _____