MEDICAL HISTORY REVIEW

Patient Name:_____ Date:_____

Chief Complaint:_____

Are you **ALLERGIC** to any medications?(Circle one): YES NO
If yes, please list: _____

Please list all medications, vitamins and herbal supplements that you are currently taking:

_____

_____

FEMALE PATIENTS:
Are you pregnant?(Circle one): YES NO
Are you planning to become pregnant soon?(Circle one) YES NO
Are you taking birth control pills?(Circle one) YES NO
Are you breast feeding?(Circle one): YES NO

PLEASE CIRCLE ALL MEDICAL CONDITIONS THAT YOU HAVE OR HAVE HAD IN THE PAST:

-Hepatitis
-Diabetes
-Arthritis
-Glaucoma
-Cataracts
-HIV
-Hayfever
-Asthma
-Cold Sores
-Easy Bruising
-Allergies
-Stomach Ulcers
-Tuberculosis
-Mononucleosis
-High Cholesterol
-Pacemaker
-Poor Wound Healing

-High Blood Pressure
-Fainting Spells
-Skin Cancer, If yes, please list type and location:
_____
-Cancer(other than skin)
Type:_____
Problems with your:
-Kidneys
-Liver
-Heart
-Urinary System
-Hormonal System
-Genital System
-Gastrointestinal system
Explain:_____

-Excessive or keloid scarring
-Hypo-or hyper-thyroid
-Emotional or psychological conditions. Please Explain:
_____
- Any moles or birthmarks that have changed size, shape, color, texture or bleed, itch, burn, hurt? If yes, please explain: _____
_____
- Do you take antibiotics before dental appointment? Please explain:_____
_____
- Other:_____
_____

SOCIAL HISTORY:
How often do you drink alcoholic beverages?(Circle one): Everyday Socially Never
Which tobacco products do you use?(Circle one): Cigarettes Cigars Pipe Other None
Do you spend a lot of time outside?(Circle one): Yes No Explain:_____
Have you had very bad sunburns in the past?(Circle one): Yes No
Do you wear sunscreen regularly?(Circle one): Yes No

MEDICAL HISTORY INFORMATION:

Patient Name:_____ Date:_____

FAMILY HISTORY:

In your family, anyone with:

Skin Cancer?	YES	NO	Relation:_____
Melanoma?	YES	NO	Relation:_____
Abnormal Moles?	YES	NO	Relation:_____
Acne?	YES	NO	Relation:_____
Dermatitis?	YES	NO	Relation:_____
Actinic Keratosis?	YES	NO	Relation:_____
Psoriasis?	YES	NO	Relation:_____
Eczema?	YES	NO	Relation:_____
Other?_____			Relation:_____

SURGICAL HISTORY:

Please list any type of surgery you've had and the date they occurred.

TYPE OF SURGERY	DATE OF SURGERY

Referring Physician(if applicable):_____
Referring Physician's Phone Number:_____

DERMATOLOGY OFTEN REQUIRES PHOTOS TO BE TAKEN. I AUTHORIZE ACADEMIC ALLIANCE IN DERMATOLOGY TO OBTAIN CONFIDENTIAL PHOTOGRAPHS. *Initial:* _____

X_____ ____ **Date:**_____
Signed (Patient or Parent/Guardian)

Reviewed with Patient (Doctor's Signature):_____