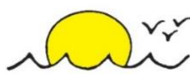
Atlantic Dermatology Associates, P.C.
Dermatology and Dermatologic Surgery

# Dermatology Medical History

Patient: ______________________ Date of Birth: ____/____/____ Today's Date: ____/____/____

Reason for today's visit: ______________________

Are you allergic to any medications? ☐Yes ☐ No If yes, list below:

______________________

Have you ever had dental anesthesia (Novocaine)? ☐Yes ☐No Any bad reaction? ☐ Yes ☐ No

List all medications you are currently taking (including prescriptions/over the counter/vitamins/herbals)

| | | |
|---|---|---|
| | | |
| | | |

**Preferred Pharmacy:**______________________ **Location:**______________________

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

**Lungs:** Yes No

- Bronchitis ---------- ☐ ---------- ☐
- Emphysema---------- ☐ ---------- ☐
- Chronic Cough---------- ☐---------- ☐
- Morning Cough ---------- ☐---------- ☐
- Shortness of Breath ---------- ☐---------- ☐
- Wheezing ---------- ☐---------- ☐

**Cardiovascular:** Yes No

- High Blood Pressure ---------- ☐ ---------- ☐
- Chest Pain ---------- ☐ ---------- ☐
- Heart Attack---------- ☐---------- ☐
- Heart Murmur ---------- ☐ ---------- ☐
- Irregular Heartbeat---------- ☐ ---------- ☐
- Phlebitis---------- ☐ ---------- ☐
  - Inflammation of vein ---------- ☐ ---------- ☐
  - Blood clots ---------- ☐ ---------- ☐
- **Pacemaker ----------** ☐**----------**☐

**Other Systemic:** Yes No

- Diabetes ---------- ☐ ---------- ☐
  - Excessive Thirst/Hunger ---------- ☐ ---------- ☐
  - Amputation ---------- ☐ ---------- ☐
  - Thyroid ---------- ☐ ---------- ☐
  - Kidney ---------- ☐ ---------- ☐
  - Dialysis ---------- ☐---------- ☐
- Bladder ---------- ☐ ---------- ☐
  - Frequency/burning **----------** ☐ **----------** ☐
- Gastrointestinal ---------- ☐---------- ☐
- Stomach absorptive disorder ---------- ☐ ---------- ☐
- Nausea absorptive disorder ---------- ☐---------- ☐
- Nausea, Vomiting, Diarrhea when taking antibiotics ---- ☐---------- ☐
- Yeast infection when taking antibiotics ---------- ☐ ---------- ☐
- Arthritis/Joint Deformity---------- ☐ ---------- ☐
  - Arthralgia ---------- ☐ ---------- ☐
  - Artificial Joints ---------- ☐ ---------- ☐
  - Limited Motions---------- ☐ ---------- ☐
- Fainting **----------** ☐ **----------** ☐
- Convulsions, Epilepsy, or Seizures---------- ☐ ---------- ☐
- Anxiety---------- ☐ ---------- ☐
- Depression---------- ☐ ---------- ☐

List any other diseases or conditions: ______________________

List surgical procedures you have had in the last 6 months: ______________________

**Skin:** Have you ever had skin cancer? ----------☐ Yes ☐ No

Has anyone in your family had skin cancer? ----------☐ Yes ☐ No

Do you have a history or any specific skin diseases? ------☐ Yes ☐ No If yes ______________

Do you have problems with healing? ----------☐ Yes ☐ No

Do you develop Keloids (raised scars) after surgery? -----☐ Yes ☐ No

Do you bleed easy? ----------☐ Yes ☐ No

Do you develop skin rashes in reaction to: ☐ Medication ☐ Food ☐ Environment ☐Bandages ☐ Topical Neosporin ☐ Other:

______________________

**Social History:**

Do you drink alcohol? -------- ☐ Yes ☐No If YES ____________ 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

Please answer the following question:

**(Women) are you pregnant?**

What is your occupation? ______________________ Hobbies? ______________________

Completed by: ☐ Patient

☐ Medical Assistant _____
Initials

______________________ ____/____/____
Signed by Patient/Parent/Guardian Date