TrueSkin

Dermatology & Surgery, Inc.

MEDICAL HISTORY

Patient's name: ____________________________ Date of Birth: ______________ Age: ______

What is / are you skin problem(s)? ____

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What **oral** and **topical** medications do you take routinely or occasionally (include birth control pills, aspirin, ibuprofen, over-the-counter medications, vitamins and moisturizers, creams or lotions)? ______________________

____

Do you have any **drug allergies**? YES NO If yes, please list drug(s) and reaction(s): ______________________

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So that Dr. Harrison can determine how much sun you have been exposed to over your lifetime, please indicate your ethnic origin **and** where you lived from birth to 20 years old.

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How did you hear about our office?

☐ Word of mouth	☐ Have previously seen Dr. Harrison	☐ Insurance list of providers
☐ Television ad	☐ Yellow pages	☐ Mailer
☐ Newspaper ad	☐ Referred by Dr. ______________	☐ Other: ______________

Do you have, or have you ever had...? 1

	YES	NO
Skin cancer (non-melanoma)	☐	☐
Melanoma	☐	☐
Cancer (other than skin)	☐	☐
Eczema	☐	☐
Hayfever / seasonal allergies / sinus	☐	☐
Asthma	☐	☐
Lung disease or shortness of breath	☐	☐
Blood clots	☐	☐
Abnormal bleeding or bruising	☐	☐
High or low blood pressure	☐	☐
Heart murmur or irregular heartbeat	☐	☐
Pacemaker or heart trouble	☐	☐
Problems with skin pigmentation	☐	☐
Keloid or excessive scarring	☐	☐
Had a reaction to local anesthesia	☐	☐
Cold sores or genital herpes	☐	☐
Organ transplant	☐	☐
HIV and / or AIDS	☐	☐
Stroke, convulsions, seizures	☐	☐
Psychological or psychiatric care	☐	☐

	YES	NO
Diabetes	☐	☐
Thyroid Disease	☐	☐
Arthritis / joint pain	☐	☐
Jaundice, hepatitis, liver disease	☐	☐
Kidney problems	☐	☐

Does your family have a history of...? 2

Eczema, hayfever, asthma	☐	☐
Psoriasis	☐	☐
Skin cancer (non-melanoma)	☐	☐
Melanoma	☐	☐

Do you or have you had...? 3	YES	NO
Drink alcohol	☐	☐
Smoke / chew tobacco	☐	☐
Go to tanning salons	☐	☐
Had X-ray treatment to your skin	☐	☐
Had severe or blistering sunburn(s)	☐	☐

What is your occupation? ______________________

Women only	YES	NO
Are you pregnant or nursing?	☐	☐
Do you have irregular periods?	☐	☐

Is there anything else you would like the doctor to know? If yes, please describe ______________________

____

Patient Signature ____ Date ______________

I have reviewed this history form ________________________________ M.D. Date ______________

(1 Review of Systems & Past Medical History, 2 Family History, 3 Social History) 10/01/09