The Art and Science of Dermatology

HISTORY FORM

Date of Visit: _____ **Allergies:** _____

Name: _____

Age: _____ DOB: _____ Sex: _____

Race: _____

For nurse only:
Sent at request of: _____
Estab Pt _____ New Pt _____
PCP _____

Pregnant? No Yes / # weeks_____ Trying to get pregnant? No Yes Breastfeeding? No Yes # mos. pp _____

#1 Most Important reason for visit today: _____

Body site(s) involved: _____

How long has this been a problem? _____

Any & all treatments? Past: _____

Present: _____

Treatment(s) that helped: _____

Other Symptoms (itching, pain, burning, other): _____

MEDICATIONS: **LIST ALL** meds taken on a **regular AND as-needed** basis. **Include prescription meds, over-the-counter meds, vitamins, herbals, supplements, and Rx & OTC topical meds (creams, ointments, solutions, etc.)**

Personal Dermatology History:

Which of the following best describes your skin type without sunscreen?

☐ Very fair, always burns, never tans ☐ Medium, sometimes burns, always tans ☐ Brown, never burns, always tans

☐ Fair, always burns, sometimes tans ☐ Olive/light brown, rarely burns, always tans ☐ Dark brown or black, never burns, always tans

Y N Wear sunscreen daily on face/neck? Y N elsewhere daily?_____ Y N when out in sun for longer time
Y N Skin Cancer (type(s): _____ > Location on body: _____
Y N Dysplastic/Abnormal Moles (biopsy-proven)
Y N Psoriasis
Y N Eczema
Y N Acne
Y N Keloids (abnormal scars)
Y N Cold Sores/Fever Blisters/ Herpes
Y N Sensitive, easily irritated skin. Y N Face only Y N All over
Y N Trouble tolerating sun screen Y N Face only Y N All over Reaction: Y N Acne Y N itchy &/or burning rash
Y N Rash in response to other on skin _____
Y N Bleed easily? Due to _____
Y N Problems with healing? Due to _____
Y N Other skin diseases/problems _____

Y N Tanning bed use: # _____
Y N Bad Sunburns: lifetime # _____
Y N Blistering sunburns # _____
Y N Rash from Sun _____

Family Dermatology History:

Y N Skin Cancer who and type _____
Y N Dysplastic/Abnormal Moles (biopsy-proven) who _____
Y N Psoriasis who _____
Y N Eczema who _____
Y N Other _____

Name: _____ DOB: _____

Review of Systems: Please check the problems you have had in the last few weeks or currently have.

___Fever ___Weight Loss ___ Weight Gain ___ Fatigue	___ Watery, Itchy Eyes ___ Blurred Vision ___ Swelling Around Eyes	___ Blood in Urine ___ Painful Urination ___Irregular Periods ___Kidney Stones	___ Chest Pain ___ Swelling in Legs ___ Leg pain when Walking	___ Joint Pain/Stiffness ___ Swelling of Joints ___ Muscle Weakness ___Muscle Pain
___ Allergies ___Hives ___Itching ___Runny Nose	___ Difficulty Swallowing ___ Sore Throat ___ Ulcers in Mouth ___ Hearing Loss	___ Wheezing ___Shortness of Breath ___ Chronic Cough	___ Headaches ___ Fainting or blackouts ___ Dizziness ___Numbness/Tingling	___ Anxiety ___ Depression ___Memory Loss ___Confusion
	___ Dry Skin ___ Heat or Cold Intolerance ___Excessive Thirst ___Excessive Urination	___ Easily Bruise/Bleed ___Swollen Glands ___Phlebitis	___ Nausea/Vomiting ___ Diarrhea ___ Abdominal Pain ___ Indigestion/Reflux	___ Teeth Grinding ___ Excessive Sweating
For any areas checked above please provide details:				

Past Medical History: Please check the problems you have or have had in the past.

___Pacemaker/Defibrillator
___**Artificial heart valve**
___ High Blood Pressure
___ Heart Attack
___Irregular Heartbeat
___Other Heart Disease
___ High Cholesterol
___ Blood Clots
___ Stroke/TIAs (mini stroke)
___ Vascular Disease
___ Diabetes
___ Kidney Disease
___ Thyroid Disease

___ Allergies/Hay Fever
___ Eczema
___ Asthma
___ Emphysema
___ Tuberculosis/+PPD
___ Other Lung Disease
___ Bleeding Disorder
___ Anemia
___Raynauds
___Lupus
___ Fibromyalgia
___ Other Auto-Immune Disease
___ Psoriasis

___ GERD (reflux) or other GI problem
___ Stomach Ulcers
___ Hepatitis
___ Psychiatric diagnosis _____
___ Headaches
___ Seizures
___ HIV/AIDS
___ Cold Sore/Herpes
___Other Sex. Transmit. Disease
___Arthritis, type _____
___ Osteoporosis/Osteopenia
___ Cancer – where/type _____
___ **Artificial Joint(s): _____**
surgery date(s) _____

List any other conditions/problems not listed above: _____
_____

List any past or upcoming surgeries: _____
_____

Social History:

Alcohol: □Y □ N If so, drinks per day _____ or drinks per week_____
Cigarette smoking: □Y □ N Prior If yes or prior > _____ packs per day for # _____ years
IV drug use □Y □N If yes, explain _____
Occupation _____
Hobbies _____

I have been informed and understand that the best skin exam is done with no makeup or nail polish on and completely naked (including underwear off). I take responsibility for areas that are covered. I understand that hair (especially if thick) covering the head prevents a perfect scalp exam and accept such limitations. Patient Initials _____ Date _____

Completed by: □ Patient/Parent/Guardian _____ _____/_____/_____
Signed by patient &/or guardian **Date of Visit**

□ Staff Member_____
(initials) _____ _____/_____/_____
Reviewed by Provider **Date of Visit**

Side 2 of 2 - sided form