

**Board Certified Dermatologists**

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**MEDICAL HISTORY FORM**

Name \_\_\_\_\_ Date \_\_\_\_\_

**Reason for visit/ current skin problem**

\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** (please list any drugs and type of allergic reaction)

\_\_\_\_\_  
\_\_\_\_\_ Tape \_\_\_\_\_ Antibiotic creams \_\_\_\_\_ Latex \_\_\_\_\_

**Current Medications:** (include herbal supplements, vitamins and/or over the counter medications)

\_\_\_\_\_  
\_\_\_\_\_

**Pregnancy:** Are you pregnant? \_\_\_\_\_ Breastfeeding? \_\_\_\_\_ Are you planning a pregnancy in the future? \_\_\_\_\_

Medical History: Please list any current or past medical conditions or cancers, including skin :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History:**

\_\_\_Melanoma \_\_\_Asthma \_\_\_Allergies/ Hay fever \_\_\_Thyroid disease \_\_\_Hair Loss

**Social History:**

Occupation: \_\_\_\_\_

Alcohol use (list per week) \_\_\_\_\_ Tobacco use (list packs per day) \_\_\_\_\_

**Major Surgeries:**

\_\_\_\_\_  
Date \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_  
Date \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_  
Date \_\_\_\_\_ Date \_\_\_\_\_

**Major Hospitalizations:**

\_\_\_\_\_  
Date \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_  
Date \_\_\_\_\_ Date \_\_\_\_\_

**Do you have any of the following? Please circle any positive answers.**

Constitutional: Chills, fatigue, fever, weight gain or weight loss

Eyes: Blurred vision, sensitivity to light

CV: Rapid heart beat, feet and leg swelling, varicose veins

GU: Genital lesions

MS: Joint aches, muscle aches, joint stiffness

Skin: Itching, sensitivity to light, rash

Neuro: weakness, dizziness, tingling, loss of skin sensation

Heme: Easy bruising, excessive bleeding

Endo: Hair loss, excessive hair growth, dark color in skin, significant stretch marks, excessive sweating

Allergy: Seasonal allergies, hives

Psy: Depression, Suicidal thoughts