

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 and/or Hospitalizations:

_____	Date _____	_____	Date _____
_____	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 heartbeat, 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

Preferred Pharmacy:

Name: _____ Address: _____ Phone: _____