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DERMATOLOGY ASSOCIATES OF THE SOUTHBAY

MEDICAL HISTORY

PATIENT: _____ Date: _____/_____/_____

What is your reason for todays visit? _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, please explain below

1) _____ 2) _____

If you answered YES above (fill out):

Location (pls circle one): Skin Local Abdomen Systemic/anaphylactic

Reaction (pls circle one): Rash Itchiness Patchy Swelling-skin Facial swelling Hives

Severity (pls circle one): Mild Moderate Severe

Have you ever had dental anesthesia? ☐ Yes ☐ No Any bad reactions? ☐ Yes ☐ No

List all **Medications** and **Milligrams** you are currently taking (including prescriptions, over-the-counter meds., vitamins and herbals):

1) _____ 3) _____ 5) _____

2) _____ 4) _____ 6) _____

Do you have now, or have you ever had diseases or conditions of: (Please check yes or no)

Lungs

Bronchitis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Chronic cough	☐ Yes	☐ No
Seasonal Allergies	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

Cardiovascular

High Blood Pressure	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Irregular hear beat	☐ Yes	☐ No
Phlebitis	☐ Yes	☐ No
Inflamation of vein	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No

Other Systemic

Diabetes	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Thyroid Disorder	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Organ Transplant	☐ Yes	☐ No
Immune System Disorder	☐ Yes	☐ No
Bleeding or Blood Disorder	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Gastrointestinal Disorder	☐ Yes	☐ No
Autoimmune Disease	☐ Yes	☐ No
Yeast infection when taking antibiotics	☐ Yes	☐ No
Arthritis/ Joint Deformity	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No
Convulsions, Epilepsy or Seizures	☐ Yes	☐ No
Fainting	☐ Yes	☐ No

List any other diseases or conditions _____

List any surgical procedures you have had in the past six months _____

Skin:

Have you ever had skin cancer?	☐ Yes	☐ No	Type_____
Has anyone in your family had skin cancer?	☐ Yes	☐ No	Type_____
Do you have a history of any specific skin diseases?	☐ Yes	☐ No	
Do you have problems with healing?	☐ Yes	☐ No	
Do you develop keloids (scars) after surgery?	☐ Yes	☐ No	
Do you have a history of blistering sunburns?	☐ Yes	☐ No	
Do you have a history of tanning bed use?	☐ Yes	☐ No	

Do you have (in compliance w/CA OSHA Title 8, Section 5199):

A history of Tuberculosis?	☐ Yes	☐ No
Night sweats?	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Painful, swollen glands?	☐ Yes	☐ No

Date of last immunization:

Shingles: _____

Pneumonia: _____

Flu & Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken, pox, meningitis, MRSA (body aches, runny nose, sore throat, nausea, vomiting, diarrhea, fever & respiratory symptoms, severe coughing, spasms, painful-swollen glands, skin rash-blisters, stiff neck) ☐ Yes ☐ No

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	

(Women) Are you pregnant? ☐ Yes ☐ No Due Date: ____ / ____ / _____

Hobbies? _____

Signed by Patient _____ Date_____