PALO DURO
DERMATOLOGY

DERMATOLOGY MEDICAL HISTORY FORM

Name_____ **DOB** __/__/____ **Reason for today's visit** _____

Occupation_____**Type of work** _____

Any factors contributing to your condition_____

General Medical History: (Please check all that apply)

No contributing history	☐	Heart Murmur	☐
Antibiotics prior to dental procedure	☐	Hepatitis	☐
Anticoagulants	☐	High Blood Pressure	☐
Artificial Joints	☐	HIV/AIDS	☐
Asthma	☐	Hives	☐
Bleeding Disorder	☐	Kidney Stones	☐
Breast Cancer	☐	Pacemaker/Defibrillator	☐
Cancer	☐	Stroke	☐
Diabetes	☐	Thyroid Disorder	☐
Eczema	☐	Tuberculosis	☐
Hay Fever/Seasonal Allergies	☐	X-Ray Therapy	☐
Heart Disease	☐		

Past Surgeries/Hospitalizations (If None, please print none)

Skin History: (Please circle all that apply)

No contributing history	Psoriasis
Actinic Keratosis	Severe Sunburns
Basal Cell Carcinoma	Squamous Cell Carcinoma
Eczema	Tanning Bed Use
Malignant Melanoma	Urticaria (Hives)
Other Suspicious Lesion	

Family History: (Please circle all that apply)

No contributing history	Unknown-Adopted	Autoimmune Disorder
Colon Cancer	Diabetes	Glaucoma
High Blood Pressure	High Cholesterol	Liver Disease
Lung Disease	Melanoma	Obesity
Premature Coronary Heart Disease	Other Skin Cancer	Thyroid Disease

Allergies to medications and type of allergic reactions: (example: hives, difficulty breathing, swelling) _____

_____

Current Medication:_____

_____

Social History: (Please answer all that apply)

Smoking History: Yes No How long?_____ **Are you still smoking? Yes No How much?**_____

Do you drink alcohol? Yes No How much? _____

Signature of person filling out this form_____**Date**_____