

## Advanced Dermatology and Skin Care Specialist DERMATOLOGIC HISTORY

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

### Past Skin History

- Do you have a history of any of the following? If Yes, Please X and complete

		Previous Treatment	Treating Physician	Date of Treatment	Location of Treatment	Note
	<b>No significant skin history</b>					
	Actinic Keratosis					
	Clarks Nevus					
	Eczema					
	Keloids					
	Other Problem elsewhere on Skin?					
	Other Suspicious Lesion(s)					
	Psoriasis					
	Rosacea					
	Urticaria					

### Past Medical History

- Do you have a history of any of the following? IF Yes, Please X.

	No Pertinent Past Medical History	Hepatitis	Psoriasis
	Arthritis	High Blood Pressure	Reflux
	Asthma	High Cholesterol	Skin Cancer
	Blood Disorders	HIV/AIDS	Stroke
	Cancer	Joint Replacement	Thyroid Disease
	Congestive Heart Failure	Kidney Disease	List Others Below:
	COPD	Liver Disease	
	Depression	Lupus	
	Diabetes	Malignant Melanoma	
	Heart Attack	Pacemaker	
	Heart Valve Replacement	Pre-Cancerous Growths	

## Family History

- Do you have a blood relative with any of the following? If Yes, Please X.

	No Contributing Family History	Family Member:
Abnormal Moles		
Arthritis		
Asthma		
Cancer		
Depression or suicide attempt(s)		
Diabetes		
Eczema (atopic dermatitis)		
Hair Loss		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Malignant Melanoma		
Pre-Cancerous Growths		
Psoriasis		
Rosacea		
Skin Cancer		
Vitilgo		

## Social History

- Please mark an X by all that apply

<b>Alcohol</b>	<b>Choose 1 of 3 below</b>	
Denies alcohol use	Current tobacco non-user	
Admits alcohol use socially	Current tobacco smoker	
Admits alcohol use daily	Current smokeless tobacco user	
<b>Illegal Drugs</b>	<b>Current Smokers-packs per day</b>	<b>Past Smokers- How long ago did you quit?</b>
Denies Illegal drugs use	< 1 pack per day	Quit < 1 year ago
Admits illegal drug use	1 pack per day	Quit 1-5 years ago
<b>High Risk Behavior</b>	2 packs per day	Quit 5-10 years ago
Denies high risk factors	3 packs per day	Quit 10-15 years ago
Admits high risk factors	4 packs per day	Quit 15-20 years ago
<b>STD</b>	4+ packs per day	Quit > 20 years ago
Denies STD history	<b>Current Smokers-duration</b>	
Admits STD history	For < 5 years	
<b>Hepatitis</b>	5-10 years	
Denies Hepatitis history	10-15 years	
Admits Hepatitis history	15-20 years	
<b>HIV/AIDS</b>	20-25 years	
Denies HIV/AIDS history	> 25 years	
Admits HIV/AIDS history		

**Please Circle Your Response:**

<b>Skin Type</b>	Dry	Oily	Combination	
<b>Skin is</b>	Easily Irritated		Not Easily Irritated	
<b>Tan</b>	Always Burn	Tans	Somewhere in the middle	
<b>Sunscreen/Sunblocks</b>	Uses		Does Not Use	
<b>How Often do you use sunscreen/sunblocks</b>	Never	Sometime	Always	
<b>SPF</b>	15	30	50	60

Do you need antibiotics before you have dental work	Do need	Do not need
Have you ever had dental anesthesia (Novocaine)?	Has	Has Not
Have you had a bad reaction to this anesthesia?	Has	Has Not
Do you wear contact lenses?	Yes	No
Do you have artificial joints?	Yes	No
What Type of work do you do?		
Do you have a dental plate?	Yes	No
If over 65 years old, have you ever had a pneumonia shot?	Have	Have not
Have you had a flu shot this year?	Have	Have not

<b>FEMALES ONLY</b>	
Date of last menstrual period	
Are your periods regular?	Yes No
Why type of contraception (if any) do you use?	
Do you have problem with excessive hair? If so where?	

May we leave a message on your answering machine?	Yes	No
May we leave a message on at your place of employment?	Yes	No
May we discuss your medical condition with a member of your household?	Yes	No
If yes, what phone number?		
What is relationship to you?		
<b>Their Name</b>		

**Please list all current medications and their dosages:**

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