Dermatology of Coastal Sarasota

MEDICAL HISTORY FORM

Name ___________________________________ Date ___/___/____

Reason for visit	Location	How long has it lasted?	Any symptoms? itch / pain	Any medications or treatments help?
1.				
2.				

List all prescription medications AND herbs AND over the counter medications: - we can photocopy your list

1.____________________________2.____________________________3.______________________

4.____________________________5.____________________________6.______________________

Medication allergies (describe reaction)?____

Do you have now, or have you ever had any of the following diseases ?

	Yes	No		Yes	No
Allergies	❑	❑	High Blood Pressure	❑	❑
Arthritis	❑	❑	Heart Murmur	❑	❑
Artificial joint	❑	❑	Pacemaker	❑	❑
Asthma	❑	❑	Seizures	❑	❑
Blood clots	❑	❑	Sleep apnea	❑	❑
Cancer (type)	______________________		Stroke	❑	❑
Diabetes	❑	❑	Thyroid	❑	❑
Heart attack	❑	❑	Ulcers / Reflux	❑	❑

Other conditions: ____

Do you have any of the following symptoms ?

	Yes	No		Yes	No
Allergy to tape	❑	❑	Dry skin	❑	❑
Bleeding tendency	❑	❑	Problems healing	❑	❑
Depression / anxiety	❑	❑	Scar easily	❑	❑
Dry eyes	❑	❑	Vision changes	❑	❑

Surgical / Dermatology History: (Please check)

	YES	**NO**
Have you ever had eye surgery ?		
Have you had atypical / dysplastic moles ?		
Have you had melanoma skin cancer ?		
Have you had other skin cancer? If so, circle which type it was. 1) Basal cell 2) Squamous Cell 3) Can't recall		
Has anyone in your family had skin cancer?		

Social History: (Please check)

	YES	NO	**If YES, how much?**
Do you drink alcohol ?			
(Woman) Are you pregnant ?			
Do you smoke?			
Do you use sunscreen?			