DERMATOLOGY SAN ANTONIO

Diplomats of the American Board of Dermatology
General, Surgical and Cosmetic Dermatology

Shavano Commons Business Park **Helotes Country Village** **Westover Hills** **Singing Hills**

Medical History

Patient Name: _____ **DOB:** _____ / _____ / _____

Referring MD: _____ **Height** _____ **Weight** _____ **Flu Vaccination: Yes** _____ **No** _____

Pharmacy Name_____**Pharmacy Phone Number** _____

Current Medications & Supplements
(*If none, please print none*)

Medication Name	Dosage	Medication Name	Dosage

Allergies
(*If none, please print none*)

Allergy	Reaction	Allergy	Reaction

Patient Past Medical History
(*Please check appropriate boxes*)

No Pertinent Past Medical History		Hepatitis / HIV / Tuberculous (TB)	
Antibiotics Prior to Routine Dental Procedures		High Blood Pressure	
Asthma/COPD		Kidney Disorder	
Autoimmune Disorder/Lupus		Liver Disorder	
Bleeding Disorder		Neurologic Disorder/MS/Dementia	
Blood Clot/DVT/Thrombophlebitis		Pacemaker/Defibrillator	
Cancer (Other than skin cancer)		Radiation Therapy	
Depression/Psychiatric Disorder		Reflux/Peptic Ulcers/Crohn's/Ulcerative Colitis	
Diabetes		Thyroid Disorder	
Heart Disease/Murmur		Other History	

Skin History
(*Please check appropriate boxes*)

No Significant Skin History		Other Suspicious Lesion(s)	
Actinic Keratosis		Eczema	
Basal Cell Carcinoma		Seasonal/Food Allergies	
Squamous Cell Carcinoma		Urticaria / Hives	
Malignant Melanoma		Keloids	
Abnormal Mole(s)		Psoriasis	

Medical History *Continue*

Family History
(*Please check appropriate boxes*)

No Contributing Family History		Hives/Urticaria	
Adopted		Psoriasis	
Malignant Melanoma		Autoimmune Disorder/Lupus	
Skin Cancer (Basal Cell/Squamous Cell Carcinoma)		Keloids	
Asthma		Abnormal Clotting/DVT	
Seasonal Food Allergies		Other Family History, please list:	

Past Surgical History

Name of Surgery: _____ Date of Surgery: _____ / _____ / _____

Name of Surgery: _____Date of Surgery: _____ / _____ / _____

SOCIAL HISTORY
(*Please check appropriate boxes*)

Alcohol Consumption: □ None □ Socially □ Daily

UV Exposure: □ Current tanning bed use □ Past tanning bed use □ >5 Blistering sunburns □ Uses sunscreen

Smoking Status: □ Current Smoker □ Former Smoker □ Never Smoked

Review of Systems
(*Please check appropriate boxes*)

Skin: □ New or changing mole □ Rash □ Keloids / Raised scars □ Photosensitivity

Constitutional: □ Fever or chills □ Unexpected weight loss

Endocrine: □ Irregular menses □ Thyroid disorder □ Excess hair growth □ Hair loss

Hematologic: □ Bruise easily or difficulty stopping bleeds □ Clots in legs or lungs
GYN: □ Pregnant □ Nursing

Neurologic: □ Headaches □ Sudden vision loss □ Weakness

Immunologic: □ Seasonal congestion □ Wheezing □ Reynaud's / white fingers with cold

ENT: □ Sinus infection □ Dental issues □ Oral ulcers

GI: □ Abdominal pain □ Diarrhea □ Nausea or vomiting

Musculoskeletal: □ Joint pain □ Muscle weakness

Respiratory: □ Shortness of breath □ Cough

Genitourinary: □ Pain with urination □ Vaginal itching or yeast infection □ Genital ulcer

If child: is growth and development appropriate: □ Yes □ No Vaccinations up to date: □ Yes □ No

Signature: _____ **Date:** _____ / _____ / _____
(Patient or Legal Guardian)