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 **Diplomats of the American Board of Dermatology**

**General, Surgical and Cosmetic Dermatology**

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

**Medical History**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_**

**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