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

Medical History

Patient Name: ____ **DOB:** ______ / ______ / ______

Referring MD: _______________________________ **Height** _______ **Weight** _________ **Sex** ___________

Pharmacy Name____**Pharmacy Phone Number** ________________________________

Do you have a Health Care Proxy or would you like to name a surrogate decision maker? ___________________________________
(YES/NO/DECLINE)

If YES, please provide details below:

NAME:	
RELATIONSHIP:	
PHONE NUMBER:	

Do you have an Advanced Care Directive? ____
(YES/NO/DECLINE)

If YES, please provide details below:

DNR: DO NOT RESUSCITATE	
FULL CARDIOPULMONARY RESUSCITATION	
OTHER:	

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

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

Signature: ____ **Date:** _______ / _______ / _______
(Patient or Legal Guardian)