CAROLINA DERMATOLOGY MEDICAL HISTORY FORM

Name ______________________________ Date ______________
Address ______________________________ SS# ______________
______________________________ DOB ______________
Home Phone ______________________ Office Phone ______________

Reason for visit

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Allergies: (please list any drugs and type of allergic reaction)
_____ Tape _____Neosporin/Polysporin _____ Latex/Rubber _____ Soaps/Cleansers
_____ Medication Allergies ____
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Pregnancy: Are you pregnant? _____ Breastfeeding? _____
Are you planning a pregnancy in the future? _____

Current Medical Problems: (under care of physician or self-treating)
_____ Asthma _____ Allergies/Hay Fever _____ Thyroid Disease

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____

Current Medications: (include herbal and over the counter medications)

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Past Medical Problems: (include surgeries)

___ Melanoma (thickness, treatment and date below)
___ Artificial Heart Valves
___ Artificial Joints
___ Problems with Local Anesthesia
___ Easy bruising
___ Other skin cancer: (list type, treatment, date below)
___ H/O Keloids, Thickened scars
___ Mitral valve prolapse/Heart murmur
___ Pacemaker/Defibrillator
___ Previous or current Accutane therapy

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Family History: ___ Melanoma ___ Asthma ___ Allergies/Hay Fever ___ Hair Loss

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Social History: Occupation
Alcohol use (list per week) ____________ Tobacco use (list packs per day) ____________

Review of Systems: <u>(Please check any current symptoms listed below)</u>

___ Photosensitivity
___ Allergies/Atopy
___ Runny nose/Sore throat
___ Fever/Chills/Headache/Fatigue
___ Swollen glands
___ SOB/Cough
___ Stomach pain/Blood in urine or stools
___ Chest pain/Irregular heartbeat
___ Swelling of the legs/Varicose veins
___ Joint aches/Muscle weakness
___ Nerve pain or damage/Dizziness
___ Sensitivity to light
___ Hearing deficit/Ringing in the ears
___ Low blood count
___ Easy bruising
___ Weight loss/Gain
___ Hair loss
___ Painful urination
___ Nausea/Vomiting/Diarrhea