Chart No. _____

DAKOTA DERMATOLOGY

Date: _____

Medical History for Dermatology

Patient Name: _____
(Last) (First) (Middle)

Birthdate: _____ **Age:** _____ **Sex:** ❒ Male ❒ Female

Who is your Primary Care Physician?_____
What is your skin problem? (rash, growth, wart, etc.) _____
Where is it at? _____
When did you first notice this skin problem? _____
Has a doctor prescribed anything for the skin? _____
Have you used any over-the counter products on the skin? _____

Past Medical History:

- ❒ Anxiety
- ❒ Arthritis
- ❒ Asthma
- ❒ Atrial fibrillation
- ❒ Bone Marrow Transplantation
- ❒ Benign Prostatic Hyperplasia (BPH)
- ❒ Breast Cancer
- ❒ Colon Cancer
- ❒ COPD/emphysema
- ❒ Coronary Artery Disease
- ❒ Depression
- ❒ Diabetes
- ❒ End Stage Renal Disease
- ❒ GERD (acid reflux)
- ❒ Hearing Loss
- ❒ Hepatitis
- ❒ High Blood pressure
- ❒ HIV/AIDS
- ❒ High Cholesterol
- ❒ Hyperthyroidism
- ❒ Hypothyroidism
- ❒ Leukemia
- ❒ Lung Cancer
- ❒ Lymphoma
- ❒ Prostate Cancer
- ❒ Radiation Treatment
- ❒ Seizures
- ❒ Stroke
- ❒ Other: _____
- ❒ **NONE**

Past Surgical History:

- ❒ Appendix Removed
- ❒ Bladder Removed
- ❒ Mastectomy (Right, Left, Bilateral)
- ❒ Lumpectomy (Right, Left, Bilateral)
- ❒ Breast Biopsy (Right, Left, Bilateral)
- ❒ Breast Reduction
- ❒ Breast Implants
- ❒ Colectomy: Colon Cancer Resection
- ❒ Colectomy: Diverticulitis
- ❒ Colectomy: Inflammatory Bowel Disease
- ❒ Gallbladder Removed
- ❒ Coronary Artery Bypass
- ❒ Mechanical Valve Replacement
- ❒ Biological Valve Replacement
- ❒ Heart Transplant
- ❒ Joint Replacement, Knee (Right, Left, Bilateral)
- ❒ Joint Replacement, Hip (Right, Left, Bilateral)
- ❒ Joint Replacement within last 2 years
- ❒ Kidney Biopsy (Nephrectomy)
- ❒ Kidney Removed (Right, Left)
- ❒ Kidney Stone Removal
- ❒ Kidney Transplant
- ❒ Ovaries Removed: Endometriosis
- ❒ Ovaries Removed: Cyst
- ❒ Ovaries Removed: Ovarian Cancer
- ❒ Prostate Removed: Prostate Cancer
- ❒ TURP (Prostate Removal)
- ❒ Spleen Removed
- ❒ Testicles Removed (Right, Left, Bilateral)
- ❒ Hysterectomy: Fibroids
- ❒ Hysterectomy: Uterine Cancer
- ❒ Other: _____
- ❒ **NONE**

Skin Disease History:

- ❒ Acne
- ❒ Actinic Keratoses
- ❒ Asthma
- ❒ Basal Cell Cancer
- ❒ Blistering Sunburns
- ❒ Dry Skin
- ❒ Eczema
- ❒ Flaking or Itchy Scalp
- ❒ Hay Fever/Allergies
- ❒ Melanoma
- ❒ Poison Ivy
- ❒ Precancerous Moles
- ❒ Psoriasis
- ❒ Squamous Cell Cancer
- ❒ **NONE**

Do you wear Sunscreen? ❒ Yes ❒ No If yes, what SPF#? _____
Do you tan in a tanning salon? ❒ Yes ❒ No

(Over)

Family History:

Do you have a family history of Skin Cancer? ❒Yes ❒ No

If yes, what type (BCC, SCC, Melanoma) and which relative(s)?_____

Family History of Other Skin Diseases or Cancer (Only first degree relatives)

_____

_____

Medications: * Required *

(Please list **all** current and over-the-counter medication(s) including doses and frequency, or you may bring your medication(s) with you.

_____

_____

_____

❒ **NONE**

Allergies: (Please list all allergies):_____

❒ **NONE**

Social History:

Cigarette Smoking/Tobacco : ❒ Never ❒ Currently How Much?_____ ❒Former

Alcohol Consumption: ❒ None ❒ Less than 1 Drink ❒ 1-2 Drinks/Day ❒ 3+ Drinks/Day

Do you currently have any of the following? (Check all that apply)

- ❒ Problems with bleeding
- ❒ Problems with healing
- ❒ Problems with scarring (hypertrophic/keloid)
- ❒ Immunosuppression
- ❒ Hay fever
- ❒ Chest pain
- ❒ Fever or chills
- ❒ Night sweats
- ❒ Unintentional weight loss
- ❒ Thyroid problems
- ❒ Sore Throat
- ❒ Blurry vision
- ❒ Abdominal pain
- ❒ Bloody stool
- ❒ Bloody urine
- ❒ Joint aches
- ❒ Muscle weakness
- ❒ Neck stiffness
- ❒ Headaches
- ❒ Seizures
- ❒ Cough
- ❒ Shortness of breath
- ❒ Wheezing
- ❒ Anxiety
- ❒ Depression
- ❒ **NONE**

ALERTS: (Check all that apply)

- ❒ Allergy to Adhesive
- ❒ Allergy to Latex
- ❒ Allergy to Lidocaine
- ❒ Allergy to topical antibiotics
- ❒ Artificial heart valve
- ❒ Artificial joint replacement
- ❒ within 2 years
- ❒ Blood thinners
- ❒ Defibrillator
- ❒ MRSA
- ❒ Pacemaker
- ❒ Require antibiotics prior to surgical procedure
- ❒ Rapid heartbeat with epinephrine
- ❒ **NONE**

Are you pregnant? ❑ Yes, Due Date:_____ ❑ No ❑ Not Applicable

Last Flu Shot_____ Previously Received Pneumonia Shot? ❑ Yes ❑ No

Preferred Pharmacy Name:_____

City and State:_____ Pharmacy Phone Number:_____