

DAKOTA DERMATOLOGY

Chart No. _____

Medical History for Dermatology

Date: _____

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:

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

Past Surgical History:

- | | |
|---|---|
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Kidney Stone Removal |
| <input type="checkbox"/> Bladder Removed | <input type="checkbox"/> Kidney Transplant |
| <input type="checkbox"/> Mastectomy (Right, Left, Bilateral) | <input type="checkbox"/> Liver: Hepatectomy, Liver Transplant, Shunt |
| <input type="checkbox"/> Lumpectomy (Right, Left, Bilateral) | <input type="checkbox"/> Ovaries Removed: Endometriosis, Cyst, Ovarian Cancer |
| <input type="checkbox"/> Breast Biopsy (Right, Left, Bilateral) | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Breast Reduction, Implants | <input type="checkbox"/> Pancreas: Pancreatectomy |
| <input type="checkbox"/> Colon (Colostomy) | <input type="checkbox"/> Prostate Removed: Prostate Cancer |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection | <input type="checkbox"/> Prostate Biopsy |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> Rectum: APR, Low Anterior Resection |
| <input type="checkbox"/> Colectomy: Inflammatory Bowel Disease | <input type="checkbox"/> TURP (Prostate Removal) |
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Skin: Basal Cell Carcinoma, Squamous Cell Carcinoma, Melanoma |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Spleen Removed |
| <input type="checkbox"/> Mechanical Valve Replacement | <input type="checkbox"/> Testicles Removed (Right, Left, Bilateral) |
| <input type="checkbox"/> Biological Valve Replacement | <input type="checkbox"/> Uterus (Hysterectomy): Fibroids, Uterine Cancer, Cervical Cancer |
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart: Angioplasty | _____ |
| <input type="checkbox"/> Joint Replacement, Knee (Right, Left, Bilateral) | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Joint Replacement, Hip (Right, Left, Bilateral) | |
| <input type="checkbox"/> Kidney Biopsy | |
| <input type="checkbox"/> Kidney Removed (Right, Left) | |

Skin Disease History:

- | | | |
|--|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Eczema | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Basal Cell Cancer | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Squamous Cell Cancer |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Melanoma | <input type="checkbox"/> NONE |

Do you wear Sunscreen? Yes No If yes, what SPF#? _____

Do you tan in a tanning salon? Yes No? Past Current

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 Drink 3+ Drinks/Day

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

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

ALERTS: (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergy to Adhesive | <input type="checkbox"/> Artificial joint replacement within 2 years | <input type="checkbox"/> Require antibiotics prior to surgical procedure |
| <input type="checkbox"/> Allergy to Latex | <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Rapid heartbeat with epinephrine |
| <input type="checkbox"/> Allergy to Lidocaine | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Allergy to topical antibiotics | <input type="checkbox"/> MRSA | |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Pacemaker | |

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: _____