

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? (First & Last Name) _____

Name of Clinic _____

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

Past Surgical History:

- | | |
|---|--|
| <input type="checkbox"/> Appendix Removed | <input type="checkbox"/> Kidney Removed/Nephrectomy |
| <input type="checkbox"/> Mastectomy (Right, Left) | <input type="checkbox"/> Kidney Transplant |
| <input type="checkbox"/> Lumpectomy (Right, Left) | <input type="checkbox"/> Liver Transplant |
| <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Ovaries Removed |
| <input type="checkbox"/> Breast Implants | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Colon Removed/Colectomy | <input type="checkbox"/> Prostate Removed |
| <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> TURP (Prostate Removal) |
| <input type="checkbox"/> Coronary Artery Bypass | <input type="checkbox"/> Skin Cancer: Basal Cell Carcinoma,
Squamous Cell Carcinoma, Melanoma |
| <input type="checkbox"/> Mechanical Valve Replacement | <input type="checkbox"/> Testicles Removed (Right, Left) |
| <input type="checkbox"/> Biological Valve Replacement | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Joint Replacement, Knee (Right, Left) | |
| <input type="checkbox"/> Joint Replacement, Hip (Right, Left) | |

Skin Disease History:

- | | |
|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> Dysplastic Nevus |
| <input type="checkbox"/> Basal Cell Cancer | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Squamous Cell Cancer |
| <input type="checkbox"/> Hay Fever/Allergies | <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

OVER →

Family History:

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

If yes, what type (Basal Cell, Squamous Cell, Melanoma) and which relative(s)? _____

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

Medications: * Required *

Please list **all** current prescriptions and over-the-counter medication(s) including mg and how often you take each, 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/Day 1-2 Drinks/Day 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

Are you breastfeeding? Yes No

Last Flu Shot: _____ Previously Received Pneumonia Shot? Yes No Shingles Shot? Yes No

Preferred Pharmacy Name: _____

City and State: _____