Chart No. _____

DAKOTA DERMATOLOGY

Medical History for Dermatology

Date: _____

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:

- ☐ 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
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Epilepsy
- ☐ Stroke
- ☐ Other: _____
- ☐ **NONE**

Past Surgical History:

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

Skin Disease History:

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Cancer
- ☐ Eczema
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Dysplastic Nevus
- ☐ Psoriasis
- ☐ Squamous Cell Cancer
- ☐ **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)

- ☐ 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

Are you breastfeeding? ☐ Yes ☐ No

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

Preferred Pharmacy Name:_____

City and State:_____