Chart No. \_\_\_\_\_

## DAKOTA DERMATOLOGY

Date: \_\_\_\_

## **Medical History for Dermatology**

Patient Name:					
Birthdate:	Age:	(First)		(Middle)  :     Male   Female	
Who is your Primary Care Physicia	· ·				
	-	-			
What is your skin problem? (rash, §					
Where is it at?					
When did you first notice this skin	problem?				
Has a doctor prescribed anything fo	or the skin? _				
Have you used any over-the counte	er products or	the skin?			
Past Medical History: Anxiety Arthritis Asthma Atrial fibrillation Benign Prostatic Hyperplasia Breast Cancer Colon Cancer COPD/Emphysema Coronary Artery Disease	( n (BPH) (	GERD ( Hearin Hepati High B HIV High C	es age Renal Disease (acid reflux) g Loss		
· ·	ft) nt		Squamous Ce Testicles Removed Hysterectomy	emoval) Isal Cell Carcinoma, Il Carcinoma, Melanoma	_
Skin Disease History:  Acne Actinic Keratoses Basal Cell Cancer Eczema Hay Fever/Allergies			Melanoma Dysplastic Nevus Psoriasis Squamous Cell Can NONE	ncer	
Do you wear Sunscreen?	es 🗆 No	If y	es, what SPF#?		
Do you tan in a tanning salon? TY	es □ No □	Past 🗆 0	Current		OVER -

Family History:  Do you have a family history of Skin Cancer?							
Family History of Other Skin Diseases or Cancer (Only first degree relatives)							
Medications: * Required * Please list all current prescriptions and or you may bring your medication(s) w  ☐ NONE		ion(s) including m	g and how often you take each,				
<b>Allergies</b> : (Please list all allergies):							
□ NONE							
Social History: Cigarette Smoking/Tobacco: □ N Alcohol Consumption: □ None	Never						
Do you currently have any of the  Problems with bleeding Problems with healing Problems with scarring (hypertrophic/keloid) Immunosuppression Hay fever Chest pain Fever or chills Night sweats	following? (Check all that Unintentional well Thyroid problems Sore Throat Blurry vision Abdominal pain Bloody stool Bloody urine Joint aches Muscle weakness	ight loss	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	<ul> <li>Artificial joint rep within 2 years</li> <li>Blood thinners</li> <li>Defibrillator</li> <li>MRSA</li> <li>Pacemaker</li> </ul>	olacement   □	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: Previo	ously Received Pneumonia S	Shot? □ Yes □ No	Shingles Shot? ☐ Yes ☐ No				
Preferred Pharmacy Name:							
City and State:							