

CAROLINA DERMATOLOGY

MEDICAL HISTORY FORM

Name _____ Date _____
Address _____ SS# _____
_____ DOB _____
Home Phone _____ Office Phone _____

Reason for visit

Allergies: (please list any drugs and type of allergic reaction)

____ Tape ____ Neosporin/Polysporin ____ Latex/Rubber ____ Soaps/Cleansers
____ Medication Allergies _____

Pregnancy: Are you pregnant? ____ Breastfeeding? ____
Are you planning a pregnancy in the future? ____

Current Medical Problems: (under care of physician or self-treating)

____ Asthma ____ Allergies/Hay Fever ____ Thyroid Disease

Current Medications: (include herbal and over the counter medications)

Past Medical Problems: (include surgeries)

____ Melanoma (thickness, treatment and date below)	____ Other skin cancer: (list type, treatment, date below)
____ Artificial Heart Valves	____ H/O Keloids, Thickened scars
____ Artificial Joints	____ Mitral valve prolapse/Heart murmur
____ Problems with Local Anesthesia	____ Pacemaker/Defibrillator
____ Easy bruising	____ Previous or current Accutane therapy

Family History: ____ Melanoma ____ Asthma ____ Allergies/Hay Fever ____ Hair Loss

Social History:

Occupation _____

Alcohol use (list per week) _____ Tobacco use (list packs per day) _____

Review of Systems: (Please check any current symptoms listed below)

____ Photosensitivity	____ Chest pain/Irregular heartbeat	____ Low blood count
____ Allergies/Atopy	____ Swelling of the legs/Varicose veins	____ Easy bruising
____ Runny nose/Sore throat	____ Joint aches/Muscle weakness	____ Weight loss/Gain
____ Fever/Chills/Headache/Fatigue	____ Nerve pain or damage/Dizziness	____ Hair loss
____ Swollen glands	____ Sensitivity to light	____ Painful urination
____ SOB/Cough	____ Hearing deficit/Ringing in the ears	____ Nausea/Vomiting/Diarrhea
____ Stomach pain/Blood in urine or stools		