Dermatology of Coastal Sarasota

MEDICAL HISTORY FORM

Name _____ Date ___/___/____

Reason for visit	Location	How long has it lasted?	Any symptoms? Itch / pain	Any medications or treatments help?
1.				
2.				

List all prescription medications AND herbs AND over the counter medications: - we can photocopy your list

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Medication allergies (describe reaction)?_____

Do you have now, or have you ever had any of the following diseases?

	Yes	No		Yes	No
Allergies	❑	❑	Heart Attack	❑	❑
Arthritis	❑	❑	Heart Murmur	❑	❑
Artificial joint	❑	❑	Immunosuppressed	❑	❑
Asthma	❑	❑	Organ Transplant	❑	❑
Blood clots	❑	❑	Pacemaker	❑	❑
Cancer (type)		_____	Psoriasis	❑	❑
Diabetes	❑	❑	Seizures	❑	❑
Eczema	❑	❑	Stroke	❑	❑
High Blood Pressure	❑	❑	Thyroid	❑	❑

Other conditions: _____

Do you have any of the following symptoms?

	Yes	No		Yes	No
Allergy to tape	❑	❑	Hair loss	❑	❑
Bleeding tendency	❑	❑	Problems healing	❑	❑
Depression / anxiety	❑	❑	Scar easily	❑	❑
Dry skin	❑	❑	Weight changes	❑	❑

Surgical / Family History: (Please check)

	YES	NO
Has anyone in your family has autoimmune disorders?		
Have you had atypical / dysplastic moles?		
Have you had melanoma skin cancer?		
Have you had other skin cancer? If so, circle which type it was. 1) Basal cell 2) Squamous Cell 3) Can't recall		
Has anyone in your family had skin cancer?		

Social History: (Please check)

	YES	NO	If YES, how much?
Do you drink alcohol?			
(Woman) Are you pregnant?			
Do you smoke?			
Do you use sunscreen?			