Highlands Dermatology Medical History

Patient Name:_____ Date of Birth:_____

Reason for today's visit: _____

Please mark the condition(s) or disease(s) that you currently have, or have had in the past:

☐ Arthritis ☐ Coronary Artery Disease ☐ Hypercholesterolemia(High Cholesterol) ☐ Stroke
☐ Asthma ☐ Diabetes ☐ Hypertension(High Blood Pressure) ☐ Cancer-Type:_____
☐ A-Fib (Irregular Heartbeat) ☐ GERD/Acid Reflux ☐ Hyperthyroidism/☐Hypothyroidism ☐ None
☐ COPD/Emphysema ☐ Hepatitis ☐ Seizures ☐ Other:_____

Please list any surgical procedures you have had in the past 6 months: ☐ None _____

Do you have a family history of the following? Diabetes: ☐ Mother/☐ Father High Blood Pressure: ☐ Mother/☐ Father
Elevated Cholesterol: ☐ Mother/☐ Father ☐ None

Did you receive a flu vaccine during this flu season? ☐ Yes ☐ No *Have you had your pneumonia vaccine?* ☐ Yes ☐ No
Do you currently smoke tobacco? ☐ Yes ☐ No *Have you ever smoked in the past*? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No *If yes:* ☐ less than 1 drink per day ☐ 1-2 per day ☐ More than 3 per day

Please mark the skin conditions or disease that you currently have, or have had in the past:

☐ Acne ☐ Actinic Keratosis ☐ Blistering Sunburn ☐ Dry Skin ☐ Eczema ☐ Flaking/Itchy Scalp ☐ Poison Ivy ☐ Psoriasis
☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Precancerous Moles ☐ None ☐ Other:_____
☐ Melanoma *Family history of melanoma*? ☐ Yes ☐ No If yes, what is your relationship?_____
Do you use sunscreen regularly? ☐ Yes ☐ No If yes, what SPF? _____ *Do you have an allergy to Neosporin*? ☐ Yes ☐ No

Please list all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

☐ See attached list of medications. ☐ None

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No *If yes, please list the name of medication and type of reaction below.*

_____

Please mark all that apply:

☐ Problems with bleeding
☐ Problems with healing
☐ Problems with scarring
☐ Immunosuppression
☐ Mole that is changing
☐ Experiencing a rash
☐ Anxiety
☐ Fever or chills
☐ Headaches
☐ Joint aches
☐ Neck stiffness
☐ Night sweats
☐ Shortness of breath
☐ Pacemaker
☐ Defibrillator
☐ Artificial joints within past 2 years
☐ Artificial heart valve
☐ Require premedication prior to procedures
☐ Allergy to adhesive
☐ Allergy to topical antibiotic/ointments
☐ Pregnant or planning on becoming pregnant
☐ Allergy to Lidocaine
☐ Experience rapid heartbeat with Epinephrine
☐ Experience yeast infections with antibiotics
☐ Experience G.I. upset with
☐ Taking a blood thinner (Aspirin, coumadin,plavix etc….)
☐ None apply

Please answer to the following questions to comply with The Medicare EHR Incentive Program.
What pharmacy do you use? _____ City, State _____
What is your preferred language: _____
What is your race? ☐ White ☐ American Indian or Alaskan Native ☐ Black or African American
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other
What is your ethnicity? ☐ Hispanic or Latino ☐ ***Not*** Hispanic or Latino ☐ Unknown

Patient Signature: _____ Date: _____