Name:
DOB:
Chart:
Age:
Date:

Pinehurst Dermatology Medical History

Patient: _____ Date: _____

Reason for today's visit: _____

Have you seen another physician for this problem? ☐ YES ☐ NO

If yes, will you sign a release for medical records from this physician? ☐ YES ☐ NO

Name and address of Physician: _____

_____

Are you allergic to any medications? ☐ YES ☐ NO If yes, list below.

1 _____ 2 _____

Have you ever had dental anesthesia (novocaine)? ☐ YES ☐ NO Any bad reactions? ☐ YES ☐ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins and herbals)

1 _____ 3 _____ 5 _____

2 _____ 4 _____ 6 _____

Skin:

Have you ever had skin cancer?	☐ YES ☐ NO	
Has anyone in your family had a melanoma?	☐ YES ☐ NO	
Do you have a history of any specific skin disease?	☐ YES ☐ NO	If yes, _____
Do you have problems with healing?	☐ YES ☐ NO	
Do you develop keloids (scars) after surgery?	☐ YES ☐ NO	
Do you bleed easily?	☐ YES ☐ NO	
Do you develop skin rashes in reaction to	☐ Medications ☐ Food ☐ Environment?	_____

Have you ever had side effects from using steroids? Yes ☐ No ☐

Do you have diabetes, glaucoma, osteoporosis or tuberculosis? Yes ☐ No ☐

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Cardiovascular:	**YES**	**NO**
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	**YES**	**NO**
Diabetes	☐	☐
Excessive thirst / hunger	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐
Frequency / Burning	☐	☐
Gastrointestinal		
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea		
when taking antibiotics	☐	☐
Yeast infection when		
taking antibiotics	☐	☐
Arthritis / Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Social History

Do you drink alcohol? ☐ YES ☐ NO If YES _____ drinks per day

Do you use IV drugs? ☐ YES ☐ NO If YES, what _____ How often? _____

Do you smoke? ☐ YES ☐ NO If YES, how much? _____

Have you had of have you been exposed to HIV (AIDS)? ☐ YES ☑ NO

Please answer the following questions:

(Women) Are you pregnant? ☐ YES ☐ NO Due Date _____

What is your occupation? _____ Hobbies? _____

Completed by: ☐ Patient ☐ Medical Assistant _____ Initials

_____ Signed By Patient 1 _____ Date

_____ Reviewed By _____ Date