Kayal Dermatology & SKIN CANCER SPECIALISTS

# Dermatology Medical History

Patient: _____ Birth Date: ___/___/___ Today's Date: ___/___/___

Reason for today's visit: _____

**Are you allergic to any medications or latex?** ☐ YES ☐ NO If yes, please list below:

_____

Have you ever had dental anesthesia (Novocaine)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

**Do you have now, or have you ever had diseases any of the below 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 | ☐ | ☐ |
| Amputation | ☐ | ☐ |
| Thyroid | ☐ | ☐ |
| Kidney | ☐ | ☐ |
| Dialysis | ☐ | ☐ |
| 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: _____

**Skin:**

**Have you ever had skin cancer?** ☐ **YES** ☐ **NO**
**Has anyone in your family had skin cancer?** ☐ **YES** ☐ **NO**
**Do you have a history of any specific skin diseases?** ☐ **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 ☐ Bandages
☐ Topical ☐ Neosporin _____

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# Dermatology Medical History

**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: _____

Are you currently HIV/AIDS positive? ☐ YES ☐ NO

Please answer the following questions:

**(Women) Are you pregnant?** ☐ **YES** ☐ **NO** Due Date: ____/____/____

What is your occupation? _____ Hobbies: _____

Completed by: ☐ Patient

_____ _____

Signed by Patient Date

☐ Medical Assistant ____

_____ _____

Reviewed by Date

# MEDICATION LOG

**Patient Name:** _____ **Pharmacy:** _____ **Pharmacy #:** _____

**Allergies:** _____ **Pharmacy Address:** _____
_____ _____
_____ _____

| Medication | Dosage | Purpose | Remark |
|---|---|---|---|
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