FOREFRONT DERMATOLOGY®

MEDICAL HISTORY

Patient:_____DOB: _____/_____/_____

Pharmacy Information (name and number):_____

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

1. _____ 2._____ 3. _____

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

List ALL the medications you are current taking (including prescribed medications, over the counter vitamins, herbals, supplements)

1. _____ 2._____ 3. _____
4. _____ 5._____ 6. _____
7. _____ 8._____ 9. _____

Females: Are you pregnant? ☐ Yes ☐ No Trying to become pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No

Social History: Do you use alcohol? Circle one: Occasionally Socially Monthly Weekly Daily

Current tobacco smoker? _____ Packs per Day? _____ Former tobacco smoker (and when quit)? _____

General Medical History: Do you have now, or ever had diseases or conditions of:

Constitutional
- ☐ Fever/Chills
- ☐ Fatigue
- ☐ Appetite Change
- ☐ Weight Gain/Loss
- ☐ Dizziness
- ☐ Thirst/Hunger

Genitourinary
- ☐ Burning/Pain
- ☐ Kidney Disease

Endocrine
- ☐ Diabetes
- ☐ Dialysis
- ☐ Hair Loss
- ☐ Kidney Stones

Allergy/Immunology
- ☐ Hay Fever/Allergies
- ☐ Hepatitis A/B/C
- ☐ HIV/AIDS
- ☐ Thyroid Disease

Psychiatric
- ☐ Nervous/Anxious
- ☐ Depression
- ☐ Other _____
- _____

Neurological
- ☐ Headaches
- ☐ Epilepsy/Seizures
- ☐ Head Injury
- ☐ Stroke

Gastrointestinal
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Liver Disease
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Diverticulitis

ENT
- ☐ Bloody Nose
- ☐ Sinus Infections

Eyes
- ☐ Vision Changes
- ☐ Dryness/Irritation
- ☐ Glaucoma
- ☐ Cataracts

Musculoskeletal
- ☐ Arthritis
- ☐ Artificial Joints/Pins
- ☐ Aches/Pains
- ☐ Limited range of motion

Respiratory
- ☐ Asthma
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Bronchitis

Hematology
- ☐ Abnormal Bleeding
- ☐ Anemia

Integumentary/Skin
- ☐ Rash/Growths
- ☐ Photosensitivity
- ☐ Dryness/Peeling
- ☐ Itching
- ☐ Pigment Changes
- ☐ Bruising
- ☐ Keloids

Cardiovascular
- ☐ Blood Clots/DVTs
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Varicose Veins
- ☐ Rheumatic Fever
- ☐ Irregular heartbeats
- ☐ Atrial fibrillation

Do you have a history of organ transplants or any other types of cancer? ☐ Yes ☐ No Please list if yes:_____

_____

New Medical Conditions/Surgeries/Hospitalizations since last visit: _____

_____

Circle all skin conditions you have/have had in the past: Unusual moles Acne Eczema Psoriasis Pre-cancerous lesions

Skin cancers (Basal Cell/Squamous Cell/Melanoma) Other:_____

Have any of your immediate FAMILY members had: skin cancer, acne, psoriasis, eczema, lupus, other**? Circle and indicate relation:**

_____

Do you require preoperative antibiotics? ☐ Yes ☐ No