



LONE STAR DERMATOLOGY MEDICAL HISTORY

Patient: _____

Date: ___/___/___

Reason for today's visit: _____

Primary Care/Referring Physician: _____

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

1. _____ 2. _____ 3. _____

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

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

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

Table with columns for Lungs, Cardiovascular, and Other Systemic conditions, each with YES/NO checkboxes.

List any other diseases or conditions: _____

List surgical procedures you have had in the past 2 years: _____

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 any 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? _____

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: _____

Women, please answer the following questions:

Are you pregnant? YES NO If YES: Due Date: : ___/___/___ Are you breastfeeding? YES NO
Have you had: Hysterectomy YES NO / Bilateral Tubal Ligation YES NO

What is your occupation? _____ Hobbies? _____

Completed by: Patient/Guardian _____ Signed by Patient _____
 Medical Assistant _____ Reviewed by _____