

INNOVATIVE DERMATOLOGY
Dermatology Patient History

Date: _____

Name: _____ DOB : _____

Referring Physician _____ Fax # (____) _____

1) Describe your present problem(s), reason for consultation:

2) How long have you had your present problem (in days, weeks, or years)?

3) Prescriptions: Have you taken any prescribed medications in the past 4 weeks? Yes No

If yes, please list, and include hormones: _____

4) Other Medications: Have you taken any non-prescribed medications in the past 4 weeks? Yes No

If yes, please list, and include herbs, vitamins, cold and sinus medicines, pain relievers, and laxatives:

5) Topicals: Are you applying any prescribed or non-prescribed ointments, cremes, or lotions? Yes No

If yes, list: _____

6) Have you ever had a reaction to any medication taken by mouth, injection, or application? Yes No

If yes, list offending medicine and reaction type: _____

7) Are you allergic to Band-Aids, adhesive tape, or latex? Yes No

Past and Current Medical History (circle yes or no)

8) Do you have a bleeding or clotting disorder? Yes No

9) Do you have glaucoma, cataracts, or other serious eye disorders? Yes No

10) Do you have hearing difficulties or other diseases of the ear? Yes No

11) Do you have anemia, low white blood cell count, or low platelet count? Yes No

12) Have you ever had a blood transfusion? Yes No

13) Have you ever had hepatitis or other liver disease? Yes No

14) Have you ever had any serious disorder of the stomach or intestines? Yes No

15) Have you ever been tested for HIV / AIDS infection? Yes No

If yes, what was the test result? positive negative

16) Are you under care for coronary heart disease, high blood pressure, or other heart problem? Yes No

17) Do you have a heart pacemaker? Yes No

18) Do you have an artificial or damaged heart valve? Yes No

19) Do you have a metal plate or artificial joint in your body? Yes No

20) Have you had a major organ transplant? Yes No

21) Have you ever been treated for or had a positive skin test to tuberculosis? Yes No

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| 22) Do you have a chronic kidney or urinary tract disorder? | Yes | No |
| 23) Have you ever had a seizure or stroke? | Yes | No |
| 24) Do you suffer from migraine headaches or other serious headaches? | Yes | No |
| 25) Do you have diabetes mellitus? | Yes | No |
| 26) Do you have asthma, emphysema, or other chronic lung/respiratory disorder? | Yes | No |
| 27) Have you ever had cancer on your skin or inside your body? | Yes | No |

If yes to any of the above questions, provide details: _____

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|--|------------|----------|
| 28) Have you had, or are you currently being treated for, any significant illnesses not listed above?
If yes, list all significant illnesses not yet noted: _____ | Yes | No |
| 29) Have you ever had any operation(s) not yet noted above?
If yes, please list: _____ | Yes | No |
| 30) Have you ever had any hospitalization(s) not noted above?
If yes, please list: _____ | Yes | No |
| 31) Have you smoked cigarettes during the past 15 years?
If yes, do you currently smoke cigarettes?
If yes, how many packs per week? _____ | Yes
Yes | No
No |
| 32) Do you drink alcohol?
If yes, how many drinks per week: _____ | Yes | No |
| 33) Are you presently employed?
If yes, state occupation: _____ Current Employer: _____
If you are not employed now, list former occupation(s): _____ | Yes | No |
| 34) Are you now pregnant or could you possibly be pregnant? | Yes | No |

SIGNATURE OF PERSON COMPLETING QUESTIONNAIRE:

DATE: _____

Relationship to patient: SELF PARENT OTHER: _____