Ideal Dermatology: Medical History Form

Personal Information:

Patient Name: ______________________________________Preferred Name:___________________

Date of Birth: _________________ Gender: _______________

Primary Care Provider: _______________________________

Pharmacy & Location: ____

Email Address: ____

Would you like access to your patient portal? YES/NO

Emergency Contact: (Name and phone number):

____

Current/Past Medical History: (Please check all that apply)

❑None	❑Depression	❑Leukemia
❑Anxiety	❑Diabetes (Type: ___________)	❑Lung Cancer
❑Asthma l	❑End Stage Renal Disease	❑Lymphoma
❑Arthritis	❑GERD	❑Prostate Cancer
❑Atrial Fibrillation	❑Hearing Loss	❑Stroke
❑Bone Marrow Transplant	❑Hepatitis	❑Other:____________
❑Breast Cancer	❑High Cholesterol	___________________
❑Colon Cancer	❑High Blood Pressure	
❑COPD	❑HIV/AIDS	
❑Coronary Artery Disease	❑Hyper/Hypo Thyroidism	

Are you a current smoker? YES/NO
Are you pregnant or currently trying to get pregnant? YES/NO

Skin Disease History: (Please check all that apply) ❑None ❑Acne ❑Actinic Keratoses ❑Basal Cell Carcinoma (Location: _____________) ❑Blistering Sunburns ❑Dry Skin ❑Eczema ❑Flaking or Itchy Scalp ❑Hay Fever/Allergies ❑Melanoma (Location: _____________) ❑Poison Ivy ❑Precancerous Moles ❑Psoriasis ❑Squamous Cell Carcinoma (Location: _____________)
Other: ____

Do you wear Sunscreen? YES/NO If yes, what SPF? _______ Do you use a tanning bed? YES/NO

Do you have family history of Melanoma? YES/NO If yes, which relative(s)?
____

Medications: (Please list all herbal supplements and prescribed medications, including dosage):
____
____
____
____
List all major surgeries:
____
____

Allergies and Sensitivities:
____
Are you allergic to any medications or local anesthesia? YES/NO If yes, please list:
____

Alerts: (Please check all that apply) ❑Allergy to Adhesive ❑Allergy to Lidocaine ❑Allergy to Topical Antibiotics ❑Artificial Heart Valve ❑Artificial Joint Replacement ❑Blood Thinners ❑Defibrillator ❑History of MRSA ❑Pacemaker ❑None

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient/Guardian (Print): _______________________________ Date: _________________

Signature: ____

ideal