St. Louis Dermatology & Surgery Center

MEDICAL HISTORY

Patient Name____ Date of Birth_____________________

Reason for Visit_____________________________________ How long have you had this condition?______________

Referring Physician_____________________________ Primary Care Doctor________________________________

Are you pregnant? ☐ Y ☐ N Trying to become pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N

General Medical History: Check all conditions you have or have had in the past:

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

Genitourinary
- ☐ Burning/Pain
- ☐ Kidney Disease

ENT
- ☐ Bloody Nose
- ☐ Sinus Infections

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

Neurological
- ☐ Headaches
- ☐ Epilepsy/Seizures
- ☐ Head Injury
- ☐ Fainting Spells

Psychiatric
- ☐ Nervous/Anxious
- ☐ Depression

Gastrointestinal
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Liver Disease

Endocrine
- ☐ Diabetes
- ☐ Dialysis
- ☐ Hair Loss

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

Musculoskeletal
- ☐ Arthritis
- ☐ Artificial Joints/pins
- ☐ Aches/Pains

Respiratory
- ☐ Asthma
- ☐ Wheezing
- ☐ Shortness of Breath

Hematology/Lymphatic
- ☐ Abnormal Bleeding
- ☐ Anemia

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

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

Other Medical Conditions/surgeries/hospitalizations:____

____

Do you require antibiotics prior to dental work? ☐ Y ☐ N

Have you ever had dental anesthesia (Novocaine/Lidocaine/Epinephrine)? ☐ Y ☐ N If yes, did you have an adverse reaction? ☐ Y ☐ N If yes, please explain____

Medications (name, dose & frequency)	**Allergies**

Skin Type: When exposed to the sun do you: 1. Always burn, never tan 2. Always burn, sometimes tan 3. Sometimes burn, always tan 4. Never burn, always tan

Circle all skin conditions you have or have had in the past: Unusual Moles Acne Eczema Psoriasis

Pre Cancers Skin Cancers (Basal Cell/Squamous Cell/Melanoma) Other: ______________________________

If you or a family member has had skin cancer in the past, please list what kind, what relative and the treatment below:

____

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

Do you use tobacco? Packs per Day: _______ Quit Smoking: Y N How Long Ago? ____________

Marital status: ________ Children:_______ Occupation/Education: ________________________________

Primary Pharmacy Name:__________________________ Location/Phone Number:____________________________

Patient/Legal Guardian Signature:____ Date: ___________________