

DERMATOLOGY ASSOCIATES OF NORTHERN MICHIGAN, P.C.
 MEDICAL HISTORY FORM (REV. 8/2/2011)

Name: _____ Age: _____ Prefer to be called: _____

REFERRED BY: _____ Height: _____ Weight: _____ Date of Birth: _____

GENERAL MEDICAL HISTORY: Do you have or have you ever had any of the following?

Y N Pacemaker or defibrillator	Y N Kidney problem (what type?)	Y N HIV or AIDS
Y N Asthma	Y N Tuberculosis	Y N Hepatitis (what type?) A B C
Y N Hayfever, seasonal allergies	Y N Epilepsy or seizures	Y N Liver cirrhosis or other liver problems
Y N Diabetes, controlled with (circle): diet, medication, insulin	Y N Arthritis (if yes, osteoarthritis, rheumatoid, or psoriatic?)	Y N Nausea, vomiting, or diarrhea with antibiotics
Y N Lupus	Y N Osteoporosis	Y N Herpes-(circle) genital or mouth
Y N Overgrown scars or keloids	Y N Thyroid problem (what type?)	Y N Genital warts
Y N High cholesterol	Y N Organ transplant (what type?)	Y N Blood clots in legs (DVT)
Y N High Blood Pressure	Y N Crohn's disease or ulcerative colitis?	Y N Anemia
Y N Stroke	Y N Reflux/GERD/Heartburn or peptic ulcers	Y N Blood transfusion (when)
Y N Heart Attack	Y N Emphysema or COPD	Y N Bleeding disorder
Y N Angina/Coronary artery disease	Y N Fainting with injections	Y N Anxiety
Y N Heart Murmur or heart valve problem	Y N Melanoma	Y N Depression
Y N Have you been told to take antibiotics before dental procedures due to a heart murmur, heart valve, or artificial joint?	Y N Basal cell or Squamous cell skin cancer (where on body, when treated?)	Y N Cancer (what type, how treated, and when?)

SURGERIES

Y N Heart valve replacement	Y N Artificial joint (if yes, which one and when?)	Y N Heart bypass surgery
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FEMALE PATIENTS

Y N Are you pregnant or breastfeeding? If not, method of birth control: _____

Y N Are you contemplating pregnancy? If yes, when: _____

Y N Tubal Ligation (tubes tied)	Y N Hysterectomy (if yes, uterus only or uterus and ovaries?)	Y N Yeast Infections when taking antibiotics
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OTHER MEDICAL PROBLEMS OR SURGERIES:

ALLERGIES TO MEDICATIONS and type of allergic reaction (ex.: hives, difficulty breathing, swelling):

SKIN TYPE: If exposed to the sun in the summer without sunscreen, would you:

1. Always Burn, never tan	3. Sometimes burn, always tan gradually	5. Rarely burn, tan profusely
2. Always burn, sometimes tan	4. Burn minimally, always tan well	6. Never burn, deeply pigmented

SOCIAL HISTORY:

Y N Do you smoke or use tobacco?	Y N Do you drink alcohol	#/Day _____ #/Week _____ #/Year _____
Marital Status: _____ Children: _____ Hobbies: _____ Occupation: _____ Indoors/Outdoors		

FAMILY HISTORY: Circle any conditions affecting a blood relative. Specify who is effected below the circle.

Melanoma Basal Cell or Squamous Cell Skin Cancer Psoriasis Eczema Hayfever or Allergies Asthma Acne

SIGNATURE OF PERSON FILLING OUT FORM _____ DATE _____

PROVIDER SIGNATURE _____ DATE _____