Dorset Street DERMATOLOGY
where health meets beauty

Medical History Form

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Are you allergic to any medications? ☐Yes ☐No If yes, please list below:

_____

Have you ever had dental anesthesia (Novocaine)? ☐Yes ☐No Did you have a bad reaction? ☐Yes ☐No

List all medications, vitamins, and supplements you are currently taking: _____

_____

_____

_____

Do you have or have you ever had the following diseases or conditions (please leave blank if unknown):

Lungs:		**Other Systemic:**	
Bronchitis	☐Yes ☐No	Diabetes	☐Yes ☐No
Emphysema	☐Yes ☐No	Thyroid	☐Yes ☐No
Asthma	☐Yes ☐No	Kidney	☐Yes ☐No
Chronic Cough	☐Yes ☐No	Bladder	☐Yes ☐No
Morning Cough	☐Yes ☐No	Gastrointestinal	☐Yes ☐No
Wheezing	☐Yes ☐No	Stomach upset when taking antibiotics	☐Yes ☐No
Cardiovascular:		Yeast infection when taking antibiotics	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Arthritis/Joint deformity/Joint pain	☐Yes ☐No
Chest Pain	☐Yes ☐No	Limited motion	☐Yes ☐No
Heart Attack	☐Yes ☐No	Artificial Joint	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Convulsions, seizures, epilepsy	☐Yes ☐No
Irregular Heartbeat	☐Yes ☐No	Fainting	☐Yes ☐No
Phlebitis	☐Yes ☐No		
Pacemaker	☐Yes ☐No		

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:

Have you ever had skin cancer? ☐Yes ☐No If YES, type: _____

Has anyone in your family had skin cancer? ☐Yes ☐No If YES, type: _____

Do you have a history of any specific skin diseases? ☐Yes ☐No If YES, type: _____

Do you have 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 ☐Bandages ☐Neosporin ☐Other _____

Other History:

Do you use tobacco? ☐Yes ☐No If YES, what and how often? _____

Have you been diagnosed with or have you been exposed to HIV (AIDS)? ☐Yes ☐No

Have you been diagnosed with or do you currently have a resistant staph (MRSA) infection? ☐Yes ☐No

Have you been diagnosed with or have you been exposed to Hepatitis C? ☐Yes ☐No

(Women) Are you pregnant or breastfeeding? ☐Yes ☐No Due Date: _____

Name and location of your pharmacy: _____

Patient Signature:_____Date: _____