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Dermatology Associates of the Bay Area

www.dermatologyoffice.com

Medical History Form

500 Alfred Nobel Drive
Suite 245
Hercules, CA 94547
TEL (510) 741-7418
FAX (510) 741-7456

PATIENT NAME: _____ TODAY'S DATE ____/____/____

LAST NAME

FIRST NAME

M / F Age: _____ Date of Birth: ____/____/____ Occupation _____

Married Single Domestic Partner Separated Widowed Divorced

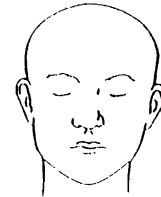
Home Phone _____ Work Phone _____

Cell Phone _____ email _____

Preferred Pharmacy (fax number if known) _____

REASON FOR VISIT: (Mark on the diagram the location of your skin condition)

How long? _____ Past treatments, if any? _____



LIST ALL CURRENT MEDICATIONS:

(Include prescriptions and over-the-counter):

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Are you allergic to any medications? YES NO

If yes, list below and describe reaction:

Have you ever had a reaction to local anesthesia? YES NO If yes, explain:

SKIN: Have you ever had? Actinic Keratoses Basal Cell Carcinoma Squamous Cell Carcinoma
 Melanoma Other _____

If yes, please provide details _____

Family history of skin cancer? YES NO If yes, please explain _____

Do you have a history of any other skin diseases? YES NO If yes, please explain _____

Have you had atypical/dysplastic moles? YES NO If yes, any removed? YES NO _____

Do you develop keloid scars in response to surgery? YES NO

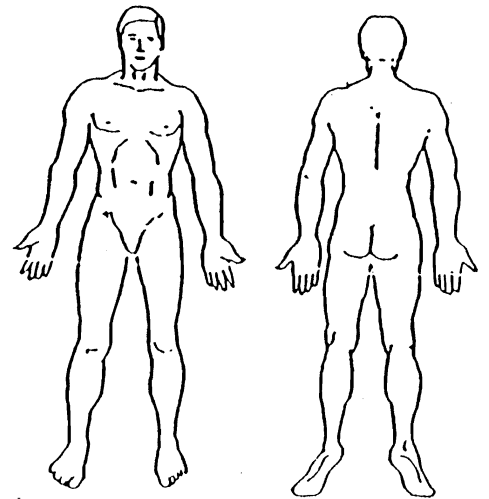
Do you develop skin rashes in reaction to? Bandages Neosporin Polysporin Other _____

Are you allergic to latex? YES NO Do you require antibiotics before dental procedures? YES NO

Do you bleed easily? YES NO

List any other diseases or conditions we should be aware of: _____

PREVIOUS SURGERY? If yes, explain type of surgery and give dates: _____



Do you have now, or have you ever had diseases/ conditions of:

Lungs:

- Asthma YES NO
- Chronic Cough YES NO
- Bronchitis/emphysema YES NO
- Tuberculosis YES NO

Cardiovascular:

- Heart Attack YES NO
- High Blood Pressure YES NO
- Irregular Heartbeat YES NO
- Phlebitis/blood clots YES NO
- Pacemaker YES NO
- Defibrillator YES NO

Neurological Disease:

- Epilepsy / Seizures YES NO
- Fainting with procedures YES NO

GYN (Women Only):

- Irregular Periods YES NO
- Are you pregnant? YES NO
- Due date _____
- Are you nursing? YES NO
- # of deliveries _____
- # of children _____
- Are you trying to get pregnant? YES NO

Other Systemic:

- Diabetes YES NO
- Thyroid YES NO
- Kidney/ Bladder Disease YES NO
- Dialysis YES NO
- Cancer, type _____ YES NO
- Organ Transplant _____ YES NO
- HIV/ AIDS YES NO

Autoimmune Disease:

- Lupus YES NO
- Connective Tissue Disease YES NO

Gastrointestinal:

- Hepatitis B or C (please circle) YES NO
- Yeast infection with antibiotics YES NO

Joint Disease:

- Arthritis YES NO
- Artificial joint YES NO

SOCIAL HISTORY:

- Do you drink alcohol? YES NO # of _____ drinks per week
- Do you smoke? YES NO how much? _____
- Have you smoked in the past? YES NO when did you stop? _____
- Do you use recreational drugs? YES NO which? _____ how often? _____

In order to better serve your dermatological needs, we ask that you mark off any subject matter below that you would like to further discuss at the time of your visit.

MEDICAL

- Skin Cancer
- Moles
- Acne/Rosacea
- Excess sweating
- Psoriasis
- Eczema

SURGICAL

- MOHS
- Cosmetic mole or tag removal

COSMETIC

- Sun damage/wrinkle correction options
- Botox
- Fillers (Collagen, Restylane, Radiesse, Juvederm)
- Skin Care Products
- Chemical Peels
- Sclerotherapy

LASER

- Hair Removal
- Fotofacial IPL rejuvenation
- Broken Blood Vessels/Telangiectasia
- Tattoo Removal
- Brown Spots
- Blue Light

OTHER: _____

Completed by: Patient

Signed by Patient

____ / ____ / ____
Date

Parent/Guardian

Your Name

____ / ____ / ____
Date