NORTHEAST DERMATOLOGY MEDICAL HISTORY FORM

NAME: _____ DATE OF BIRTH: _____

DRUG ALLERGIES

☐ **NONE** ☐ **YES**, LISTED BELOW:

LATEX ☐ NOVOCAINE ☐ EPINEPHRINE ☐ LIDOCAINE ☐ SULFUR ☐ PENICILLIN ☐

☐ OTHER DRUG ALLERGIES: _____

CURRENT MEDICATIONS

☐ **I DO NOT TAKE MEDICATIONS** ☐ I DO TAKE MEDICATIONS, LISTED BELOW:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

(Feel free to submit a list of current medications that we may copy)

ADDITIONAL MEDICAL INFORMATION

	YES	NO
DO YOU TAKE ANTIBIOTICS BEFORE YOUR TEETH ARE CLEANED?	☐	☐
DO YOU TAKE ASPIRIN OR OTHER ANTI-INFLAMMATORY AGENTS DAILY?	☐	☐

SKIN HISTORY

HAVE YOU BEEN DIAGNOSED WITH MELANOMA?	☐	☐
HAVE YOU BEEN DIAGNOSED WITH OTHER SKIN CANCERS? *BASAL CELL CARCINOMA; SQUAMOUS CELL CARCINOMA*	☐	☐
DO YOU HAVE PSORIASIS?	☐	☐
DO YOU HAVE ECZEMA?	☐	☐

PAST MEDICAL HISTORY

ASTHMA ☐ BLEEDING DISORDER ☐ CANCER ☐ DEPRESSION ☐ DIABETES ☐ HEART DISEASE ☐

HIGH BLOOD PRESSURE ☐ KIDNEY DISEASE ☐ LUNG PROBLEM ☐ LUPUS, SCLERODERMA OR CONNECTIVE TISSUE DISEASE ☐ STROKE ☐ THYROID DISORDER ☐ HIV ☐ LIVER DISEASE OR HEPATITIS ☐

OTHER, NOT LISTED ☐ _____

FAMILY HISTORY

☐ **I DO NOT HAVE ANY HISTORY OF FAMILY MEDICAL CONDITIONS** *(skip to Social History)*

I have a family history of the following:

MELANOMA ☐ PSORIASIS ☐ ECZEMA ☐ OTHER SKIN CANCERS ☐ CANCER ☐ AUTOIMMUNE DISORDERS ☐

SOCIAL HISTORY

	YES	NO		YES	NO
DO YOU DRINK ALCOHOL DAILY?	☐	☐	DO YOU SMOKE?	☐	☐
DO YOU DRINK OCCASIONALLY?	☐	☐	DO YOU WORK WITH CHEMICALS?	☐	☐

PLEASE LIST YOUR HEIGHT: _____ **WEIGHT:** _____

WHICH PHARMACY DO YOU USE?

NAME: _____ ADDRESS: _____ CITY: _____