SkinSpeaks
Advancements in Dermatology | Spa M.D.

Dermatology Medical History

PLEASE PRINT (Fill out completely)

Patient Name: _____ Date of Birth: _____
First MI Last

Primary Physician: _____ Clinic (Name, City): _____

Referring Physician, if applicable: _____ Clinic (Name, City): _____

Pharmacy (Name, Street, City): _____

Please list all prescription and over-the-counter medications you are currently taking, including baby aspirin:

_____ _____ _____ _____

_____ _____ _____ _____

Please list all known allergies, including medications: _____

Do you have a history of the following? (Check all that apply)

_____ Pacemaker/Defibrillator	_____ Convulsions, Epilepsy or Seizures	_____ Keloid, Atypical Scars	_____ HIV/AIDS
_____ Coronary Artery Disease	_____ Yeast Infection With Antibiotics	_____ Thickened Scars	_____ Stroke
_____ High Blood Pressure	_____ Basal or Squamous Cell Carcinoma	_____ Poor Healer	_____ GERD
_____ High Cholesterol	_____ Malignant Melanoma	_____ Crohns/IBS	_____ Artificial Joints
_____ Heart Attack	_____ Anxiety or Depression	_____ Organ Transplant	_____ Artificial Heart Valves
_____ Thyroid Disease	_____ Other Mental Health Disorders	_____ Hepatitis	_____ Cancer, other than skin:
_____ Kidney Disease	_____ Bleeding Disorders	_____ Asthma	_____
_____ Liver Disease	_____ Emphysema/COPD	_____ Latex Allergy	_____
_____ Diabetes	_____ Fainting	_____ Arthritis	

Other medical conditions: _____

Family history of: Skin Cancers _____ Pre-cancers _____ Malignant Melanoma _____ Atypical Moles _____

Family history of Psoriasis, Eczema, Asthma, or Allergies ☐ Yes ☐ No Details: _____

Tobacco use ☐ Current ☐ Former ☐ Never

Alcohol consumption ☐ Occasionally ☐ Daily ☐ None

Currently pregnant (For Women Only) ☐ Yes ☐ No Due Date: _____/_____/_____

Is there a possibility you could be pregnant now? ☐ Yes ☐ No

Have you ever had dental anesthesia ☐ Yes ☐ No Any adverse reaction ☐ Yes ☐ No

Occupation: _____ Hobbies: _____

Signature of Patient or Legal Representative _____ Date_____

Reviewed By _____ Date_____