SkinSpeaks
Advancements in Dermatology | Spa M.D.

Dermatology Medical History

PLEASE PRINT (Fill out completely)

Patient Name: _____ Date of Birth: _____ / _____ / _____
First MI Last MM DD YYYY

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 personal history of the following? (Check all that apply)

☐ Pacemaker/Defibrillator	☐ Convulsions, Epilepsy, or Seizure	☐ Keloids/Atypical Scars	☐ HIV/AIDS
☐ Coronary Artery Disease	☐ Yeast Infection With Antibiotics	☐ Thickened Scars	☐ Stroke
☐ High Blood Pressure	☐ Basal or Squamous Cell Carcinoma	☐ Poor Healer	☐ Fainting
☐ High Cholesterol	☐ Malignant Melanoma	☐ Organ Transplant	☐ GERD / Reflux
☐ Heart Attack	☐ Merkel Cell Carcinoma	☐ Hepatitis	☐ Artificial Joints
☐ Thyroid Disease	☐ Anxiety or Depression	☐ Asthma	☐ Artificial Heart Valves
☐ Kidney Disease	☐ Other Mental Health Disorders	☐ Latex Allergy	☐ Cancer, other than skin:
☐ Liver Disease	☐ Emphysema/COPD	☐ Arthritis	_____
☐ Diabetes	☐ Crohn's or Ulcerative Colitis (IBD)	☐ Bleeding Disorders	_____

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

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

Currently pregnant (For Women Only): . . . . . ☐ Yes ☐ No Due Date: _____ / _____ / _____
MM DD YYYY

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

Occupation: _____ Hobbies: _____

Signature of Patient or Legal Representative: _____ **Date:** _____ / _____ / _____
MM DD YYYY

Reviewed By (Healthcare Provider): _____ Date: _____ / _____ / _____
MM DD YYYY