Dermatology Medical History

SASHA Cavanagh MD DERMATOLOGY

Patient: _____ Date of Birth: ___/___/_____ Referred by: _____

Reason for today's visit: _____

_____

Are you allergic to any medications? ☐ YES ☐ NO If YES, please list below along with reaction:

_____

List all medications you are currently taking (including prescriptions and over-the-counter medications with doses)

_____

_____

Have you been vaccinated against COVID-19? ☐ No ☐ 1 dose ☐ 2 doses ☐ Booster Type: _____

Do you or your family have now, or have you ever had, the following diseases or condtions:

Pulmonary:	**Self**	**Family** (List who)
Emphysema/COPD	☐	☐_____
Asthma	☐	☐_____
Cardiovascular:		
High Blood Pressure	☐	☐_____
High Cholesterol	☐	☐_____
Heart Attack	☐	☐_____
Heart Murmur	☐	☐_____
Irregular Heartbeat	☐	☐_____
Pacemaker	☐	☐_____
Psychiatric:		
Depression	☐	☐_____
Anxiety	☐	☐_____
Neurologic:		
Seizure disorder	☐	☐_____
Stroke	☐	☐_____

Other Systemic:	**Self**	**Family** (List who)
Diabetes	☐	☐_____
Thyroid disease	☐	☐_____
Kidney disease	☐	☐_____
Dialysis	☐	☐_____
Bladder/Prostate problems	☐	☐_____
Seasonal allergies	☐	☐_____
Gastrointestinal:		
Hepatitis A/B/C	☐	☐_____
Crohn's disease	☐	☐_____
Ulcerative colitis	☐	☐_____
Arthritis/Joint Deformity:		
Arthritis type		_____
Artificial joint	☐	☐_____

List any other diseases/cancer: _____

List prior surgical procedures: _____

Please circle if you are CURRENTLY having any of the following symptoms:

GENERAL: fevers / chills / fatigue / weight loss / excessive thirst or hunger
EYES/EARS: dry eyes / vision or hearing loss / dry mouth
RESPIRATORY: cough / shortness of breath
CARDIAC: chest pain / irregular heartbeat / legs swelling
GI: nausea / vomitting / diarrhea / reflux
GU: urinary burning / frequency / incontinence
JOINTS: joint pain / swelling / muscle pain
NEURO/PSYCH: weakness / headaches / dizziness / anxiety / depression

Skin: Have you ever had skin cancer? ☐ YES ☐ NO Have you ever had Basal cell carcinoma? ☐ YES ☐ NO
Have you ever had Melanoma? ☐ YES ☐ NO Have you ever had Squamous cell carcinoma? ☐ YES ☐ NO
Please list skin cancers with sites and dates if known: _____
_____
Has anyone in your family has skin cancer? ☐ YES ☐ NO If yes, details_____
Do you have a history of specific skin diseases? ☐ YES ☐ NO If yes, details_____
Do you develop keloids (scars) after surgery? ☐ YES ☐ NO
Do you develop skin rashes to: Medications ☐ Food ☐ Bandages ☐ Neosporin ☐

Social: Do you drink alcohol? ☐ YES ☐ NO _____(per day) Do you smoke? ☐ YES ☐ NO
Do you use drugs? ☐ YES ☐ NO _____(type) What is / was your occupation? _____
Women: Are you pregnant? ☐ YES ☐ NO What are your hobbies? _____
Due Date ___/___/_____ What is your preferred pharmacy?
Are you planning a pregnancy soon? _____
☐ YES ☐ NO

Completed by: **Date:**

_____ _____/_____/_____