

Skin Center of South Miami
Medical History Review

Name _____ Date _____

Are you **ALLERGIC** to any medicines? Yes No

If yes, please list: _____

Please list all medications, vitamins and herbal supplements that you are taking:

Female patients:	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you planning to become pregnant soon? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please check all medical conditions that you have or have had in the past:

- | | | |
|---|--|---|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Excessive or keloid scarring |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Cancer. If yes, please list type and location: _____ | <input type="checkbox"/> Hypo- or hyper- thyroid |
| <input type="checkbox"/> Arthritis | | <input type="checkbox"/> Emotional or psychological conditions. Please Explain: _____ |
| <input type="checkbox"/> Glaucoma | | |
| <input type="checkbox"/> Cataracts | | |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Cancer (other than skin) Type: _____ | <input type="checkbox"/> Any moles or birthmarks that have changed size, shape, color, texture or bleed, itch burn, hurt? If yes, please explain: _____ |
| <input type="checkbox"/> Hayfever | | |
| <input type="checkbox"/> Asthma | | |
| <input type="checkbox"/> Cold Sores | Problems with your: | |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Kidneys | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Liver | |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Heart | <input type="checkbox"/> Do you take antibiotics before dental appointment? Please Explain: _____ |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Urinary system | |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Hormonal system | |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Genital system | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Gastrointestinal system | |
| <input type="checkbox"/> Poor wound healing | Explain: _____ | |

How often do you drink alcoholic beverages? Everyday Socially Never

Do you use any tobacco products? Cigarettes Cigars Pipe Other None

Do you spend a lot of time outside? Yes No Explain: _____

Have you had very bad sunburns in the past? Yes No

Do you use sunscreen regularly? Yes No

In your family, anyone with:

Skin Cancer? Yes No Relation: _____

Melanoma? Yes No Relation: _____

Abnormal moles? Yes No Relation: _____

List any other skin problem(s) in your family: _____

Patient's Signature: _____

Reviewed with Patient (Doctor's Signature): _____