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? ❑ Yes ❑ No
	Are you planning to become pregnant soon? ❑ Yes ❑ No

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

- ❑ Hepatitis
- ❑ Diabetes
- ❑ Arthritis
- ❑ Glaucoma
- ❑ Cataracts
- ❑ HIV
- ❑ Hayfever
- ❑ Asthma
- ❑ Cold Sores
- ❑ Easy bruising
- ❑ Allergies
- ❑ Stomach ulcers
- ❑ Tuberculosis
- ❑ Mononucleosis
- ❑ High cholesterol
- ❑ Pacemaker
- ❑ Poor wound healing
- ❑ High blood pressure
- ❑ Skin Cancer. If yes, please list type and location:
  _____
- ❑ Cancer (other than skin) Type:
  _____

Problems with your:

- ❑ Kidneys
- ❑ Liver
- ❑ Heart
- ❑ Urinary system
- ❑ Hormonal system
- ❑ Genital system
- ❑ Gastrointestinal system

Explain:_____
_____

- ❑ Excessive or keloid scarring
- ❑ Hypo- or hyper- thyroid
- ❑ Emotional or psychological conditions. Please Explain:
  _____
- ❑ Any moles or birthmarks that have changed size, shape, color, texture or bleed, itch burn, hurt? If yes, please explain:
  _____
  _____
- ❑ Do you take antibiotics before dental appointment? Please Explain:_____
- ❑ Other:_____
  _____
  _____

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):_____