VENICE DERMATOLOGY CLINIC PA
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PATIENT MEDICAL HISTORY (CONFIDENTIAL)

NAME_____ DATE _____

WERE YOU REFERRED BY A PHYSICIAN/CLINIC?_____ NAME _____

REASON FOR YOUR CLINIC VISIT TODAY _____

MEDICATIONS

List all medications that you are taking. Include over-the-counter meds.

MEDICATION NAME	HOW LONG	MEDICATION NAME	HOW LONG

DRUG ALLERGIES:

_____
_____
_____

SKIN SENSITIVITIES

_____
_____
_____

REVIEW OF SYSTEMS & MEDICAL HISTORY

Mark (C) for current problems. Check (X) box and indicate age when you had any of the following symptoms or diseases.

Review of Symptoms

- ☐ Hearing Problems
- ☐ Recent Weight Loss
- ☐ Nose Bleeds
- ☐ Bleed/Bruise Easily
- ☐ Irreg. Pulse
- ☐ Palpitations
- ☐ Bloody Urine
- ☐ Heart Murmur
- ☐ Difficulty Swallowing
- ☐ Sinus Problems
- ☐ Hoarseness
- ☐ Jaundice

Past Medical History

- ☐ Venerial Disease
- ☐ Syphilis ☐ Gonorrhea
- ☐ Herpes ☐ Chlamydia
- ☐ Artificial Joints
- ☐ Hypertension
- ☐ AIDS
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Seizures
- ☐ Migrane Headaches
- ☐ Stroke
- ☐ Mental Illness
- ☐ Depression
- ☐ Cancer (list below)
- ☐ Radiation Therapy
- ☐ Phlebitis
- ☐ Tuberculosis
- ☐ Heartburn/GERD
- ☐ Anemia
- ☐ HIV Positive
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Varicose Veins
- ☐ Gout
- ☐ Hepatitis
- ☐ Kidney Stones
- ☐ Peptic Ulcer Disease
- ☐ Coronary Heart Disease
- ☐ Arthritis
- ☐ Colitis
- ☐ Blood Transfusion
- ☐ Asthma
- ☐ Hay Fever

WOMEN

Regular Menstrual Periods
☐ Yes ☐ No ☐ Post-Menopausal

Nº of Pregnancies _____

Nº of Live Births _____

Nº of Miscarriages _____

Birth Control Method _____

Menopausal Symptoms ☐ Yes ☐ No

MEN

☐ Prostate Problems

SKIN HISTORY

- ☐ Eczema ☐ Psoriasis
- ☐ Abnormal Moles ☐ Hives/Urticaria
- ☐ Skin Cancer ☐ Unusual Hair Loss
- ☐ Excessive/Large Scarring

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Do you take antibiotics prior to dental work? ☐ Yes ☐ No

Do you have artificial Joints? ☐ Yes ☐ No When was surgery? _____

Do you have a heart murmur? ☐ Yes ☐ No What type? _____

Do you have a pacemaker? ☐ Yes ☐ No

Do you have a defibrillator? ☐ Yes ☐ No

Do you take **aspirin**? ☐ Yes ☐ No

Do you take **Coumadin (Warfarin)**? ☐ Yes ☐ No

Do you take **Plavix**? ☐ Yes ☐ No

Do you have a history of Hepatitis or being jaundiced? ☐ Yes ☐ No

Do you have a sensitivity to **epinephrine**? ☐ Yes ☐ No

SOCIAL HISTORY

History of Tobacco Product use (mark all that apply) ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Dip ☐ Chew

Frequency (eg. Pack/day)_____ How long (years)?_____ If Quit, when_____

Alcoholic Beverages - drinks/week _____

Coffee/Tea - cups/day_____ Recreational Drugs ☐ Yes ☐ No Type _____

Occupational Hobbies_____

FAMILY HISTORY

	Skin Cancer	Melanoma	Asthma/Hay Fever		Diabetes	Skin Disorders - Type	
Maternal Grandfather	☐	☐	☐	☐	☐	☐	
Maternal Grandmother	☐	☐	☐	☐	☐	☐	
Paternal Grandfather	☐	☐	☐	☐	☐	☐	
Paternal Grandmother	☐	☐	☐	☐	☐	☐	
Mother	☐	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	☐	
Siblings	☐	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	☐	

**DO YOU HAVE INSURANCE THAT PAYS FOR MEDICATIONS? Yes_____ No_____

DO YOU PREFER THE BEST MEDICATION RECOMMENDED FOR TREATMENT OR THE MOST ECONOMICALMEDICATION AVAILABLE?

BEST RECOMMENDED_____ MOST ECONOMICAL_____