## DERMATOLOGY ASSOCIATES

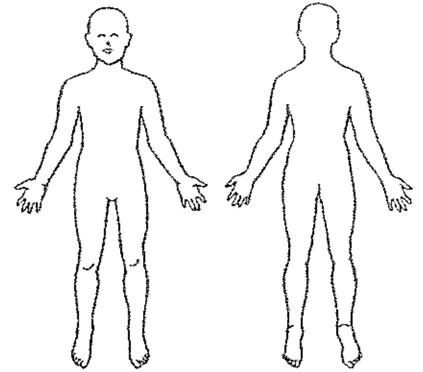
**PATIENT MEDICAL HISTORY** Today's Date: ____________________

Patient Name: ____________________________________ Date of Birth: ____________________

1. What problem are you coming in for today?
   *Please describe the problem and indicate what part of the body is affected on the figures to the right.*

   a. ________________________________________________

   b. ________________________________________________




2. How long have you had this problem? ______________________

3. Do you have a family history of:

   ___Skin cancer ___Melanoma
   ___Eczema ___Psoriasis
   ___ Other ______________________________________

4. Have you had any other skin-related problems over the past several years? YES NO

______________________________________________________

5. Are you currently using any prescription, or over-the-counter medications for your skin? If yes, what are you using? ______________________ YES NO

______________________________________________________

6. Are you currently being treated by another doctor? If yes, for what are you being treated? ____________________________________ YES NO

______________________________________________________

7. Are you allergic to any medications? If yes, please list: ____________ YES NO

______________________________________________________

8. (FOR WOMEN) Are you pregnant? YES NO

   Are you currently taking hormone, or birth control pills? YES NO

9. Is there any further information you feel your practitioner should know about your general health? Any surgeries, ulcers, asthma, or other condition?

______________________________________________________

______________________________________________________

10. Please list ALL medications you are currently taking: ______________________________

______________________________________________________

______________________________________________________

**Consent for Treatment:** ______________________________________________
(patient/patient guardian signature)

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