Ideal Dermatology: Medical History Form

Personal Information:

Patient Name: _____Preferred Name:_____

Date of Birth: _____ Gender: _____

Primary Care Provider: _____

Pharmacy & Location: _____

Email Address: _____

Would you like access to your patient portal? YES/NO

Emergency Contact: (Name and phone number):

_____

Current/Past Medical History: (Please check all that apply)

❑None
❑Anxiety
❑Asthma l
❑Arthritis
❑Atrial Fibrillation
❑Bone Marrow Transplant
❑Breast Cancer
❑Colon Cancer
❑COPD
❑Coronary Artery Disease
❑Depression
❑Diabetes (Type: _____)
❑End Stage Renal Disease
❑GERD
❑Hearing Loss
❑Hepatitis
❑High Cholesterol
❑High Blood Pressure
❑HIV/AIDS
❑Hyper/Hypo Thyroidism
❑Leukemia
❑Lung Cancer
❑Lymphoma
❑Prostate Cancer
❑Stroke
❑Other:_____
_____

Are you a current smoker? YES/NO
Are you pregnant or currently trying to get pregnant? YES/NO

Skin Disease History: (Please check all that apply) ❑None ❑Acne ❑Actinic Keratoses ❑Basal Cell Carcinoma (Location: _____) ❑Blistering Sunburns ❑Dry Skin ❑Eczema ❑Flaking or Itchy Scalp ❑Hay Fever/Allergies ❑Melanoma (Location: _____) ❑Poison Ivy ❑Precancerous Moles ❑Psoriasis ❑Squamous Cell Carcinoma (Location: _____)
Other: _____

Do you wear Sunscreen? YES/NO If yes, what SPF? _____ Do you use a tanning bed? YES/NO

Do you have family history of Melanoma? YES/NO If yes, which relative(s)?

_____

Medications: (Please list all herbal supplements and prescribed medications, including dosage):

_____

_____

_____

_____

List all major surgeries:

_____

_____

Allergies and Sensitivities:

_____

Are you allergic to any medications or local anesthesia? YES/NO If yes, please list:

_____

Alerts: (Please check all that apply) ❑Allergy to Adhesive ❑Allergy to Lidocaine ❑Allergy to Topical Antibiotics ❑Artificial Heart Valve ❑Artificial Joint Replacement ❑Blood Thinners ❑Defibrillator ❑History of MRSA ❑Pacemaker ❑None

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient/Guardian (Print): _____ Date: _____

Signature: _____