Colorado Dermatology Institute

Patient Medical History

Date: _____/_____/_____

Patient: _____ DOB: _____/_____/_____

Are you allergic to any medications? ☐ NO ☐ YES If yes, list below and explain reaction:
1._____ 2._____ 3._____

Have you ever had dental anesthesia (Novocain/Lidocaine)? ☐ YES ☐ NO Had a bad reaction? ☐ YES ☐ NO

List **ALL** the medications you are currently taking **(Prescriptions, over-the-counter meds, vitamins, and herbals)**

1._____ 2._____ 3._____
4._____ 5._____ 6._____

Do you have now, or ever have had any of the below diseases or conditions:

Lungs	YES	NO
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Cardiovascular		
High Blood Pressure	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood Clots	☐	☐
Pacemaker	☐	☐
Defibrillator	☐	☐

Other Systemic:	YES	NO
Diabetes	☐ (not controlled)	☐ (controlled)
Thyroid	☐	☐
Dialysis	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
Yeast infections when taking antibiotics	☐	☐
Artificial joint	☐	☐
Arthritis	☐	☐
Convulsions or seizures	☐	☐
Fainting	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
HIV (AIDS)	☐	☐

List all other MEDICAL/SKIN conditions: _____

_____

List all Skin Cancers, Dates, and Locations: _____

_____

Skin Specific Questions:	YES	NO	
Have you ever had any type of cancer?	☐	☐	If YES, what type? _____When? _____
Has anyone in your family had skin cancer?	☐	☐	If YES, who? _____What kind? _____
Do you have problems with healing/keloids?	☐	☐	If YES, what type of healing problems?_____
Do you bleed easily?	☐	☐	If YES, any serious bleeding episodes?_____

Do you develop skin rashes in reaction to: ☐ Medications ☐ Food ☐ Environment ☐ Bandages ☐ Topical Neosporin
Other: _____

Social History:	YES	NO	
Do you drink alcohol?	☐	☐	If YES, _____drinks/day
Do you smoke/chew tobacco?	☐	☐	If YES, type? _____, packs/day _____
Do you use IV drugs?	☐	☐	If YES, type?_____
Are you pregnant?	☐	☐	If NO, when was your LMP?_____

What is your occupation? _____ Job Duties _____

Completed by: ☐ Patient ☐ Other

_____ Date: _____
Signature of Patient

_____ Date: _____
Reviewed By