
MOORESVILLE DERMATOLOGY CENTER

MEDICAL HISTORY FORM

NAME: _____ AGE: _____ HEIGHT _____
WEIGHT: _____

Reason for today's
visit: _____

Where is it located? _____ How long has it been
present? _____

How does it bother you? Itch, painful, bleeds,
other: _____

Previous treatment: _____
Current treatment: _____

Current skin care regimen (soaps, lotions,
laundry, etc.)? _____

Time permitting, other skin problems:

Are you allergic to any medications? Yes No

If yes, please

list: _____

List all medications (oral & topical), herbal supplements or vitamins you take or have
taken in past 3
months: _____

Other questions:

Have you used Accutane in the past? Yes No

Do you need antibiotics before surgery or dental work? Yes No

Do you have an artificial heart valve, or joints? Yes No

Do you have a pacemaker or defibrillator? Yes No

Do you have a history of fainting? Yes No

ALL QUESTIONS MUST BE ANSWERED YES OR NO

Past History and Review of Systems:

- | | | |
|--|------------------------------|-----------------------------|
| Eye, ear, mouth problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Headaches, seizures, stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hay fever, allergies to food or insects | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression, anxiety, eating disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes, thyroid or hormone disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma, emphysema, TB | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart problems, pacemaker, defibrillator | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stomach, gallbladder, or bowel problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Liver problems, Hepatitis B or C | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney or urinary problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Joint pains, muscle soreness, lupus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chickenpox | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Organ Transplant | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Family History Who?

- | | |
|---|-------|
| <input type="checkbox"/> Unknown-Adopted | _____ |
| <input type="checkbox"/> Eczema/allergies | _____ |
| <input type="checkbox"/> Psoriasis | _____ |
| <input type="checkbox"/> Abnormal Moles | _____ |
| <input type="checkbox"/> Large # moles | _____ |
| <input type="checkbox"/> Pre-cancer | _____ |
| <input type="checkbox"/> Rosacea | _____ |
| <input type="checkbox"/> Acne | _____ |
| <input type="checkbox"/> Heart disease | _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Lupus | _____ |
| <input type="checkbox"/> Arthritis | _____ |

Skin History

Do you have a history of any type of skin cancer: Yes No. If you answered yes, please list type, and location: _____

Does a family member have a history of any type of skin cancer: Yes No. If you answered yes, please list type, and relationship of family member to you: _____

Do you have a specific history of any type of skin diseases? Yes No. If yes, please list: _____

Do you have problems with healing or develop keloids (scars)? Yes No

Allergic to bandaids, tape, latex, iodine or local anesthetics like lidocaine/novacaine? Yes No

Do you bleed easily? Yes No

Do you have a history of cold sores/fever blisters? Yes No

General & Social History

Alcohol use: never occasional frequent

Tobacco use: smoke dip/chew none

UV exposure: Tanning bed Yes No Sunbathe Yes No

Blistering sunburns Yes No

Sunscreen use Yes No Protective clothing/hats Yes No
Do you take part in any sports or exercise programs? Yes No
Do you have any pets? Yes No
Have you traveled abroad over the last two years? Yes No
Have you ever traveled or lived outside the USA? Yes No

Occupation:_____

Hobbies:_____

Females only

Are you pregnant? Yes No Trying to get pregnant? Yes No Breast feeding?
Yes No
Are you on birth control? Yes No Are you post menopausal? Yes No

Patient/Guardian

Signature:_____

Person Completing this form if other than
patient:_____ Relationship_____

Date Provider Reviewed:_____ Provider Initials:_____