ClearSkin Dermatology
general • cosmetic • pediatric

Patient History Form

Name: _____ DOB: _____ Date: _____

Check mark any of the following diagnosis if had:

Lungs:	**Vascular:**	**Other Systemic:**
Bronchitis	High Blood Pressure	Diabetes mellitus
Emphysema	Chest Pain	Hay fever
Asthma	Prior myocardial infarction	Osteoporosis
Chronic bronchitis	Functional murmur	Thyroid disorder
Morning coughs	Rhythm disorder	Renal disorder
	Thrombophlebitis	Bladder Disorder
	Blood Transfusion	Liver, stomach, or bowel disease

Check mark if you have any of the following:

Mitral valve prolapsed	Joint replacement	Pacemaker/defibrillator
Organ transplant	Heart defect	Artificial heart valve
Heart murmur		

Other medical history: _____

List all medications you are currently taking, including over the counter medications:

Medication	**Strength**	**How Often**	**Medication**	**Strength**	**How Often**

List your allergies (severity/outcomes) _____

SOCIAL HISTORY: Do you smoke (if so, how much/day)? _____ Do you drink alcohol (if so, how much/day)? _____

Do you use recreational drugs (if so, what and how often)? _____ Have you ever been exposed to HIV(AIDS)? _____

Occupation: _____ Employer: _____

SKIN HISTORY: Have you ever had skin cancer? _____ If yes, what type?_____

Do you pre-medicate with antibiotics before procedures? _____

Has anyone in your family had skin cancer? _____ If yes, what type? _____

Do you have a history of any specific skin diseases? _____

Have you had anesthesia (Lidocaine)? _____ If yes, have you ever had a reaction to Lidocaine? _____

What are you here for today? _____

How long has this problem been present? _____

Women: Are you pregnant? ____ Are you currently breastfeeding? ____I f no, are you planning to become pregnant? _____

Referred by: ☐ Friend ☐ Family ☐ Physician: _____ ☐ Online: _____