

# CAROLINA DERMATOLOGY

# MEDICAL HISTORY FORM

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ SS# \_\_\_\_\_  
\_\_\_\_\_ DOB \_\_\_\_\_  
Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_

## Reason for visit

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Allergies: (please list any drugs and type of allergic reaction)

\_\_\_\_ Tape \_\_\_\_ Neosporin/Polysporin \_\_\_\_ Latex/Rubber \_\_\_\_ Soaps/Cleansers  
\_\_\_\_ Medication Allergies \_\_\_\_\_

**Pregnancy:** Are you pregnant? \_\_\_\_ Breastfeeding? \_\_\_\_  
Are you planning a pregnancy in the future? \_\_\_\_

## Current Medical Problems: (under care of physician or self-treating)

\_\_\_\_ Asthma \_\_\_\_ Allergies/Hay Fever \_\_\_\_ Thyroid Disease  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Current Medications: (include herbal and over the counter medications)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Past Medical Problems: (include surgeries)

____ Melanoma (thickness, treatment and date below)	____ Other skin cancer: (list type, treatment, date below)
____ Artificial Heart Valves	____ H/O Keloids, Thickened scars
____ Artificial Joints	____ Mitral valve prolapse/Heart murmur
____ Problems with Local Anesthesia	____ Pacemaker/Defibrillator
____ Easy bruising	____ Previous or current Accutane therapy

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family History:** \_\_\_\_ Melanoma \_\_\_\_ Asthma \_\_\_\_ Allergies/Hay Fever \_\_\_\_ Hair Loss  
\_\_\_\_\_  
\_\_\_\_\_

## Social History:

Occupation \_\_\_\_\_

Alcohol use (list per week) \_\_\_\_\_ Tobacco use (list packs per day) \_\_\_\_\_

## Review of Systems: (Please check any current symptoms listed below)

____ Photosensitivity	____ Chest pain/Irregular heartbeat	____ Low blood count
____ Allergies/Atopy	____ Swelling of the legs/Varicose veins	____ Easy bruising
____ Runny nose/Sore throat	____ Joint aches/Muscle weakness	____ Weight loss/Gain
____ Fever/Chills/Headache/Fatigue	____ Nerve pain or damage/Dizziness	____ Hair loss
____ Swollen glands	____ Sensitivity to light	____ Painful urination
____ SOB/Cough	____ Hearing deficit/Ringing in the ears	____ Nausea/Vomiting/Diarrhea
____ Stomach pain/Blood in urine or stools		