MAIN LINE DERMATOLOGY
Patient Medical History

Patient Name:_____DOB:_____/_____/_____

Reason for today's visit (symptoms): _____

Are you allergic to any medications? ☐ YES ☐ NO If yes, list (Please include reaction): _____

_____

SKIN RELATED HISTORY

☐Yes	☐No	Have you ever had skin cancer?	☐Yes	☐No	Do you get rashes reactive to environment?
☐Yes	☐No	Has anyone in your family had skin cancer?	☐Yes	☐No	Do you get rashes reactive to food?
☐Yes	☐No	Do you have a history of skin diseases?	☐Yes	☐No	Do you get rashes reactive to bandages?
☐Yes	☐No	Do you bleed easily?	☐Yes	☐No	Do you get rashes reactive to Neosporin?
☐Yes	☐No	Do you have problems with healing?	☐Yes	☐No	Do you get rashes reactive to medications?
☐Yes	☐No	Do you develop scars after surgery?	☐Yes	☐No	Sensitivity to antibiotics?
☐Yes	☐No	Do you have an allergy to latex?	☐Yes	☐No	Have you ever had dental anesthesia (Novocaine)?
☐Yes	☐No	Do you have an allergy to Epinephrine?	☐Yes	☐No	Have you ever had a bad reaction to anesthesia?

GENERAL MEDICAL HISTORY – Have you had or do you have any of the following?

Lungs:			**Other Systems:**					
☐Yes	☐No	Bronchitis	☐Yes	☐No	Diabetes Type 1 or 2	☐Yes	☐No	Alzheimer's Disease
☐Yes	☐No	Emphysema	☐Yes	☐No	Excessive thirst/hunger	☐Yes	☐No	COPD
☐Yes	☐No	Asthma	☐Yes	☐No	Thyroid – Hypo/ Hyper	☐Yes	☐No	Immune disorder
☐Yes	☐No	Chronic cough	☐Yes	☐No	Kidney disease	☐Yes	☐No	Anemia
☐Yes	☐No	Shortness of Breath	☐Yes	☐No	Kidney stones	☐Yes	☐No	Shingles
☐Yes	☐No	Wheezing	☐Yes	☐No	Hepatitis A B C	☐Yes	☐No	Chicken Pox
Cardiovascular:			☐Yes	☐No	Liver Disease	☐Yes	☐No	Lupus
☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Arthritis	☐Yes	☐No	Tuberculosis
☐Yes	☐No	Chest Pain	☐Yes	☐No	Limited range of motion	☐Yes	☐No	Heart Disease
☐Yes	☐No	Heart Attack	☐Yes	☐No	Artificial joint	☐Yes	☐No	Breast Cancer
☐Yes	☐No	Congestive Heart Failure	☐Yes	☐No	Rheumatoid arthritis	☐Yes	☐No	Colon Cancer
☐Yes	☐No	Murmur/ irregular heartbeat	☐Yes	☐No	Migraines/ Headaches	☐Yes	☐No	Prostate Cancer
☐Yes	☐No	Bleeding disorder	☐Yes	☐No	Epilepsy/ Seizures	☐Yes	☐No	Bladder Cancer
☐Yes	☐No	Phlebitis- Blood clots	☐Yes	☐No	Fibromyalgia	☐Yes	☐No	Leukemia
☐Yes	☐No	Pacemaker	☐Yes	☐No	Anemia	☐Yes	☐No	Prone to fainting
☐Other:								

SOCIAL HISTORY

Do you smoke or use tobacco? ☐ Never ☐ Former smoker ☐ Current smoker Frequency: _____

Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Socially Frequency: _____

Do you have a history of drug use? ☐ Never ☐ Former user ☐ Current user Frequency: _____

Do you have or have you been exposed to HIV/ AIDS? ☐ No ☐ Yes

Are you now or do you think you may be pregnant? ☐ No ☐ Yes Due date: _____ Breastfeeding? ☐ No ☐ Yes

List surgical procedures you have had in the last six (6) months: _____

_____

List all medications you are currently taking (including prescriptions, over-the-counter medications, vitamins, and herbals):

_____

_____

Completed by:

☐ Patient or responsible party ☐ MLD Staff

_____

Patient or responsible party signature Date