

DERMATOLOGY \_\_\_\_\_ HISTORY \_\_\_\_\_

CHIEF COMPLAINT \_\_\_\_\_

HISTORY OF PRESENT ILLNESS \_\_\_\_\_

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MEDICATIONS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ALLERGIES \_\_\_\_\_

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MEDICAL HISTORY (check box if you have or have had any of the following symptoms or diseases)

- |   |   |                                    |  |
|---|---|------------------------------------|--|
| <input type="checkbox"/> HEARING PRBLEMS  | <input type="checkbox"/> CHLAMYDIA  | <input type="checkbox"/> GONORRHEA | <b>SKIN PROBLEMS</b>   |
| <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> CATARACTS            | <input type="checkbox"/> RECENT WEIGHT LOSS                                 |                                    | <input type="checkbox"/> ECZEMA <input type="checkbox"/> PSORIASIS |
| <input type="checkbox"/> NOSE BLEEDS <input type="checkbox"/> SINUS TROUBLE     | <input type="checkbox"/> ANEMIA <input type="checkbox"/> BRUISE EASILY      |                                    | <input type="checkbox"/> RASH                                      |
| <input type="checkbox"/> HOARSENESS <input type="checkbox"/> HAY FEVER          | <input type="checkbox"/> CANCER   |                                    | <input type="checkbox"/> ABNORMAL <input type="checkbox"/> MOLES   |
| <input type="checkbox"/> ASTHMA <input type="checkbox"/> HYPERTENSION           | <input type="checkbox"/> DIABETES <input type="checkbox"/> THYROID DISEASE  |                                    | <input type="checkbox"/> HIVES                                     |
| <input type="checkbox"/> CORONARY HEART DISEASE                                 | <input type="checkbox"/> SEIZURES <input type="checkbox"/> STROKE           |                                    | <input type="checkbox"/> FREQUENT SUN EXPOSURE                     |
| <input type="checkbox"/> HEART MURMUR   | <input type="checkbox"/> MIGRAINE HEADACHES                                 |                                    | <input type="checkbox"/> MIGRAINE HEADACHES                        |
| <input type="checkbox"/> PALPITATIONS <input type="checkbox"/> IRREG. PULSE     | <input type="checkbox"/> ARTHRITIS <input type="checkbox"/> GOUT            |                                    | <input type="checkbox"/> EXCESSIVE SCARRING                        |
| <input type="checkbox"/> VARICOSE VEINS <input type="checkbox"/> PHLEBITIS      | <input type="checkbox"/> MENTAL ILLNESS <input type="checkbox"/> DEPRESSION |                                    | <input type="checkbox"/> SKIN CANCER                               |
| <input type="checkbox"/> DIFFICULTY SWALLING <input type="checkbox"/> HEARTBURN | <input type="checkbox"/> TUBERCULOSIS                                       |                                    | <input type="checkbox"/> RECENT OR PROGRESSIVE HAIR LOSS           |
| <input type="checkbox"/> PEPTIC ULCER DISEASE <input type="checkbox"/> COLITIS  | <input type="checkbox"/> ALLERGIES (NON DRUG)                               |                                    | <input type="checkbox"/> PREGNANT                                  |
| <input type="checkbox"/> JAUNDICE <input type="checkbox"/> HEPATITIS            | ALCOHOL – OZ/WK _____   |                                    |  |
| <input type="checkbox"/> KIDNEY STONES <input type="checkbox"/> PROSTATE PROB   | SMOKING – DIG/DAY _____ #YEARS _____  |                                    |  |
| <input type="checkbox"/> VENEREAL DISEASE <input type="checkbox"/> HERPES       | COFFEE/TEA – CUPS/DAY _____   |                                    |  |

FAMILY HISTORY

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**THE SKIN INSTITUTE**  
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