FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

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DERMATOLOGY MEDICAL HISTORY

Patient Name: _____ Date: _____/_____/_____
Reason for today's visit: _____
Are you allergic to any medications: Yes ___No ___ If yes please list: _____
Have you had a bad reaction to dental anesthesia? Yes ___No ___ Never had dental anesthesia __
List all current medications (including prescription, over-the-counter, vitamins, and herbals)
1. _____3. _____ 5. _____7. _____
2. _____4. _____ 6. _____8. _____

Do you have now or have you ever had diseases or conditions of: (Please check yes or no)

Lungs:
Bronchitis Yes___ No___
Emphysema/COPD Yes___ No___
Asthma Yes___ No___
Heart:
High Blood Pressure Yes___ No___
Heart Attack Yes___ No___
Blood Clots Yes___ No___
Irregular Heartbeat Yes___ No___
Pacemaker Yes___ No___
Defibrillator Yes___ No___
Endocrine:
Diabetes Yes___ No___
Thyroid Yes___ No___
Kidney Yes___ No___
Dialysis Yes___ No___
Cancer:
Type:_____ Year: _____

GI:
Reflux: Yes___ No___
Stomach Problems Yes___ No___
GU: Yes___ No___
Bladder Problems Yes___ No___
Yeast Infections with Antibiotics Yes___ No___
Skeletal:
Arthritis Yes___ No___
Artificial Joint Yes___ No___
Which joint?_____When?_____
Neurological:
Memory Problems Yes___ No___
Seizures/Fainting Yes___ No___
Headaches Yes___ No___
Stroke Yes___ No___
Psychological:
Depression Yes___ No___
Anxiety Yes___ No___

Any other conditions: _____

Any major surgeries/year performed: _____

Are you currently experiencing any of the following: (Please check yes or no)

Excessive weight loss Yes ___ No ___
Fevers/chills Yes ___ No ___
Night sweats Yes ___ No ___
Headaches Yes___ No___
Enlarged lymph nodes Yes___ No___
Nausea/Vomiting Yes___ No___

Do you have now or have you ever had diseases or conditions of: (Please check yes or no)

Skin: Have you ever had skin cancer? Yes ___No ___ if yes: _____
Has anyone in your family had melanoma? Yes ___No ___ if yes: _____
Do you have a history of a skin disease? Yes ___No ___ if yes: _____
Do you have problems with healing? Yes ___No ___
Do you develop keloids (scars) after surgery? Yes ___No ___
Do you bleed easily? Yes ___No ___
Do you develop rashes to bandages or Neosporin? Yes ___No ___

Social History:
Do you drink alcohol? Yes ___No ___ if yes #_____ drinks per day
Do you or have you ever used IV drugs? Yes ___No ___ if yes, what type? _____
Do you smoke? Yes ___No ___ if yes, how much?_____
Have you been exposed to HIV (AIDS)? Yes ___No ___

What is/was your occupation? _____Hobbies? _____
(Women) Are you pregnant? Yes ___No ___ Due Date: ___/____/___

Who is your primary care provider? _____

Patient Signature: _____Date:___/___/___ Rev'd by: _____Date:___/___/___