VENICE DERMATOLOGY CLINIC PA
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PATIENT MEDICAL HISTORY (CONFIDENTIAL)

NAME______________________________________ DATE____
WERE YOU REFERRED BY A PHYSICIAN/CLINIC?_____NAME_____________________________________
REASON FOR YOUR CLINIC VISIT TODAY____
____

MEDICATIONS

List all medications that you are taking. Include over-the-counter meds.

MEDICATION NAME	HOW LONG	MEDICATION NAME	HOW LONG

DRUG ALLERGIES:
____
____
____

SKIN SENSITIVITIES:
____
____
____

REVIEW OF SYSTEMS & MEDICAL HISTORY

Mark (C) for current problems. Check (**X**) box and indicate age when you had any of the following symptoms or diseases.

Review of Systems
- ☐ Hearing Problems
- ☐ Recent Weight Loss
- ☐ Nose Bleeds
- ☐ Bleed/Bruise Easily
- ☐ Irreg. Pulse
- ☐ Palpitations
- ☐ Bloody Urine
- ☐ Heart Murmur
- ☐ Difficulty Swallowing
- ☐ Sinus Problems
- ☐ Hoarseness
- ☐ Jaundice

Past Medical History
- ☐ Venereal Disease
- ☐ Syphilis ☐ Gonorrhea
- ☐ Herpes ☐ Chlamydia

- ☐ Artificial Joints
- ☐ Hypertension
- ☐ AIDS
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Seizures
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Mental Illness
- ☐ Depression
- ☐ Cancer (list below)
- ☐ Radiation Therapy
- ☐ Phlebitis
- ☐ Tuberculosis
- ☐ Heartburn/GERD
- ☐ Anemia
- ☐ HIV Positive

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Varicose Veins
- ☐ Gout
- ☐ Hepatitis
- ☐ Kidney Stones
- ☐ Peptic Ulcer Disease
- ☐ Coronary Heart Disease
- ☐ Arthritis
- ☐ Colitis
- ☐ Blood Transfusions
- ☐ Asthma
- ☐ Hay Fever

WOMEN
Regular Menstrual Periods
☐ Yes ☐ No ☐ Post-Menopausal
N° of Pregnancies__________________
N° of Live Births__________________
N° of Miscarriages__________________
Birth Control Method_______________
Menopausal Symptoms
☐ Yes ☐ No

MEN
- ☐ Prostate Problems

SKIN HISTORY
- ☐ Eczema ☐ Psoriasis
- ☐ Abnormal Moles ☐ Hives/Urticaria
- ☐ Skin Cancer ☐ Unusual Hair Loss
- ☐ Excessive/large scarring

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Do you take antibiotics prior to dental work? ☐Yes ☐No
Do you have artificial joints? ☐Yes ☐No When was surgery?________________________________
Do you have a heart murmur? ☐Yes ☐No What type?____
Do you have a pacemaker? ☐Yes ☐No
Do you have a defibrillator? ☐Yes ☐No
Do you take **aspirin**? ☐Yes ☐No
Do you take **Coumadin** (**Warfarin**)? ☐Yes ☐No
Do you take **Plavix**? ☐Yes ☐No
Do you have a history of Hepatitis or being jaundiced? ☐Yes ☐No
Do you have a sensitivity to **epinephrine**? ☐Yes ☐No

SOCIAL HISTORY

History of Tobacco Product use (mark all that apply): ☐Cigarettes ☐Cigars ☐Pipe ☐Dip ☐Chew
Frequency (eg. Pack/day)___________________ How Long – (yrs.)__________ If Quit – when_____________
Alcoholic Beverages – drinks/week____
Coffee / Tea – cups/day__________________ Recreational Drugs ☐Yes ☐No Type___________________
Occupation or Hobbies____

FAMILY HISTORY

	Skin Cancer	Melanoma	Asthma/Hay fever		Diabetes	Skin Disorders - Type	
Maternal Grandfather	☐	☐	☐	☐	☐	☐	
Maternal Grandmother	☐	☐	☐	☐	☐	☐	
Paternal Grandfather	☐	☐	☐	☐	☐	☐	
Paternal Grandmother	☐	☐	☐	☐	☐	☐	
Mother	☐	☐	☐	☐	☐	☐	
Father	☐	☐	☐	☐	☐	☐	
Siblings	☐	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	☐	

**DO YOU HAVE INSURANCE THAT PAYS FOR MEDICATIONS? Yes_____ No_____

DO YOU PREFER THE BEST MEDICATION RECOMMENDED FOR TREATMENT OR THE MOST ECONOMICAL MEDICATION AVAILABLE ?

BEST RECOMMENDED ________ MOST ECONOMICAL__________