



DERMATOLOGY PATIENT HISTORY FORM

History of Present Illness

Referred by: Primary Care Physician: Preferred Pharmacy:

Reason for visit: How long have you had this issue?

On what area of your body?

Check the appropriate symptoms:

- Y Itching Y Painful Y Bleeding Y Burning Y Growing Y Comes and goes Y Darkening

List the medications you have used to treat this skin problem:

What skin care products do you use?

Social History

Tobacco use: Y N Do you use sun protection (clothing, hats, sunscreen)? Y N

Do you drink alcohol? Y N # drinks per day

Do you have a history of blistering sunburns? Y N Use of tanning lights Y N

How often do you use a tanning bed or lights? Y N

Extensive sun exposure Y N

Exposure to radiation Y N

(other than xrays)

Occupation: Where did you grow up?

Any changes in your health since your last visit? Y N

If so, check any changes (next page):

Name: _____ DOB: _____ Date: _____

Skin/Nails

Y	N	New or changing moles
Y	N	Localized skin discoloration
Y	N	Acne
Y	N	Skin: a rash
Y	N	Superficial skin pain burning
Y	N	Urticaria/Hives
Y	N	Allergic reaction
Y	N	Telangectasias
Y	N	Skin lesions
Y	N	Skin lesion: bleeds
Y	N	Itching (pruritus)
Y	N	Skin swelling
Y	N	Dry skin
Y	N	Skin/nail infection
Y	N	Symptoms of Nail/Skin thickening

Gynecological

Y	N	Menses abnormal
Y	N	Menarche
Y	N	Planning pregnancy
Y	N	Pregnancy
Y	N	Patient is breastfeeding
Y	N	History of miscarriages #
Y	N	Menopause has occurred

Genitourinary

Y	N	Blood in urine
Y	N	Pain during urination
Y	N	Urinary frequency
Y	N	Penile discharge
Y	N	Vaginal discharge
Y	N	Genital lesion

Musculoskeletal

Y	N	Joint pain, localized
Y	N	Joint swelling, localized
Y	N	Muscle aches
Y	N	Muscle weakness

Hematologic/Lymphatic

Y	N	Clotting problems
Y	N	Easy bleeding
Y	N	Swollen lymph nodes
Y	N	Limb swelling

Psychiatric

Y	N	Depression
Y	N	Anxiety

Cardiac

Y	N	Chest pain
Y	N	Palpitations

Constitutional

Y	N	Feeling fine
Y	N	Recent weight loss (lbs)
Y	N	Recent weight gain (lbs)
Y	N	Fever
Y	N	Feeling tired

Eyes

Y	N	Loss of part of field of vision
Y	N	White/light spots in field of vision
Y	N	Eyelid skin lesion
Y	N	Eye sores
Y	N	Eye irritation

Gastrointestinal

Y	N	Abdominal pain
Y	N	Diarrhea
Y	N	Nausea
Y	N	Vomiting
Y	N	Constipation

Endocrine

Y	N	Intolerance to heat
Y	N	Intolerance to cold
Y	N	Excessive thirst/fluid intake
Y	N	Deepening of voice
Y	N	Changed sexual interest (libido)
Y	N	Loss of hair from head or body
Y	N	Excessive facial/body hair

Ears, Nose, Throat

Y	N	Skin lesion on ears
Y	N	Skin lesion on nose
Y	N	Skin lesion on lip
Y	N	Lesions in the mouth
Y	N	Lesions on the tongue
Y	N	Stuffiness

Respiratory

Y	N	Shortness of breath
Y	N	Wheezing
Y	N	Cough

Neurologic

Y	N	Tingling
Y	N	Headache
Y	N	Numbness

Immunosuppression

Y	N	Immunosuppression drugs, leukemia, HIV or other
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