HAYDEL DERMATOLOGY MEDICAL HISTORY

Patient: _____ Date _____/_____/_____
Reason for today's visit:_____

Are you allergic to any medications? □Yes □ No If yes, list below:
1._____2._____3._____
Have you ever had dental anesthesia (Novocaine)? □Yes □ No Any bad reaction? □Yes □No

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):
1. _____ 3._____ 5._____
2. _____ 4. _____ 6._____

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

Lungs:	**YES**	**NO**
Bronchitis	□	□
Emphysema	□	□
Asthma	□	□
Shortness of Breath	□	□

Cardiovascular:	**YES**	**NO**
High Blood Pressure	□	□
Chest Pain	□	□
Heart Attack	□	□
Heart Murmur	□	□
Irregular Heartbeat	□	□
Inflammation of vein	□	□
Blood clots	□	□
Pacemaker/defibrillator	□	□

Other Systemic:	**YES**	**NO**
Diabetes	□	□
Excessive thirst/hunger	□	□
Amputation	□	□
Thyroid	□	□
Kidney	□	□
Dialysis	□	□
Gastrointestinal	□	□
Stomach absorptive disorder	□	□
Chrohn's Disease/Ulcerative Colitis	□	□
Arthritis/Joint Deformity	□	□
Joint Pain	□	□
Limited Motion	□	□
Artificial Joint	□	□
Convulsions, Epilepsy or Seizures	□	□
Fainting	□	□

Have you had or have you been exposed to HIV (AIDS)? □Yes □No
List any other diseases or conditions: _____
List surgical procedures you have had in the last 6 months: _____

Skin:	**YES**	**NO**
Do you get hives?	□	□
Do you have a history of fever blisters?	□	□
Have you ever had skin cancer?	□	□
Has anyone in you family had melanoma?	□	□
Do you have a history of any specific skin diseases?	□	□
Have you ever taken Accutane?	□	□
Do you develop keloids (scars) after surgery?	□	□
Do you bleed easily?	□	□
Are you on blood thinners?	□	□
Do you get nausea, vomiting, diarrhea or yeast infections from taking oral antibiotics?	□	□

Do you develop skin rashes in reaction to □Medications □ Food □ Poison Ivy □Bandages □ Topical Neosporin □ Other __

Social History:
Do you drink alcohol? □ Yes □ No If YES, _____ drinks per day
Do you use IV drugs? □ Yes □ No If YES, what? _____How often?_____
Do you smoke? □ Yes □ No If YES, how much? _____

(Women) Are you pregnant? □ Yes □ No Due date: ___/___/___
What is your occupation? _____
Do you have a history or tendency of fainting during medical procedures? □ YES □ NO
CAN LAB TEST RESULTS BE LEFT ON YOUR ANSWERING MACHINE? □ YES □ NO

NOTE: ALL BIOPSIES ARE SENT TO DR. T. NICOTRI, A SKIN PATHOLOGIST; *SEPARATE CHARGES WILL BE INCURRED FROM HIS OFFICE*. PLEASE INQUIRE AT FRONT DESK IF YOUR INSURANCE IS ACCEPTED BY DR. NICOTRI.