DERMATOLOGY HISTORY CHECKLIST

PATIENT NAME_____DATE_____

LIST ANY MAJOR ILLNESS _____

LIST SURGERIES _____

DO YOU HAVE A HISTORY OF: (circle yes or no)

HYPERTENSION (HIGH BLOOD PRESSURE) **yes/no** DIABETES **yes/no**
HEART DISEASE **yes/no**

DO YOU HAVE A PROSTHETIC DEVICE? **yes/no**
(PACE MAKER, HIP OR KNEE REPLACEMENT, HEART VALVE)

LIST ALL MEDICATION (INCLUDING ASPIRIN, LAXATIVES, VITAMINS & OVER-THE-COUNTERS MEDS) YOU TAKE

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? **yes/no**

if yes, please list _____

DO YOU HAVE ANY FOOD ALLERGIES? **yes/no**

if yes, please list _____

DO YOU HAVE ANY ENVIRONMENTAL ALLERGIES? **yes/no**

if yes, please list _____

DO YOU OR A FAMILY MEMBER HAVE A HISTORY OF ASTHMA OR HAYFEVER? **yes/no**

DO YOU GET A LOT OF SUN EXPOSURE, OR HAVE YOU HAD A LOT OF SUN EXPOSURE IN THE PAST? **yes/no**

HAVE YOU EVER HAD SKIN CANCER? **yes/no**

DO ANY FAMILY MEMBERS HAVE A HISTORY OF SKIN CANCER? **yes/no**

DO ANY FAMILY MEMBERS HAVE A HISTORY OF MELANOMA? **yes/no**

HAVE YOU EVERY HAD X-RAY TREATMENT FOR ACNE , THYROID, ETC? **yes/no**

WHEN YOU ARE EXPOSED TO SUNLIGHT DO YOU…

BURN _____ BURN THEN TAN_____ TAN ONLY_____