# VIRGINIA STREET DERMATOLOGY – CONFIDENTIAL MEDICAL HISTORY

**NAME**__________________________________ **DOB**__________________ **DATE**_____________________________

**Were you referred to our practice by your Primary Care Physician?** __________________________________________________

## REVIEW OF SYSTEMS

| | YES | NO |
|---|---|---|
| Feeling Well | ___ | ___ |
| Fever | ___ | ___ |
| Weight Gain/Loss | ___ | ___ |
| **SKIN** | | |
| Rash | ___ | ___ |
| Suspicious Mole | ___ | ___ |
| **HEENT** | | |
| Hearing Loss | ___ | ___ |
| Visual Disturbances | ___ | ___ |
| **RESPIRATORY** | | |
| Wheezing | ___ | ___ |
| Difficulty Breathing | ___ | ___ |
| **GASTROINTESTINAL** | | |
| Crohn's Disease | ___ | ___ |
| Gluten Sensitivity | ___ | ___ |
| Ulcerative Colitis | ___ | ___ |
| **MUSCULOSKELETAL** | | |
| Joint Pain | ___ | ___ |
| Swelling of Extremities | ___ | ___ |
| **NEUROLOGIC** | | |
| Headaches | ___ | ___ |
| Stroke | ___ | ___ |
| Seizures | ___ | ___ |
| **PSYCHIATRIC** | | |
| Depression | ___ | ___ |
| Anxiety | ___ | ___ |
| **HEMATOLOGIC** | | |
| Blood Clots | ___ | ___ |
| Enlarged Lymph Nodes | ___ | ___ |
| **ENDOCRINE** | | |
| Thyroid Problems | ___ | ___ |
| Hair Changes | ___ | ___ |

## MEDICAL HISTORY

| | YES | NO |
|---|---|---|
| Asthma/COPD | ___ | ___ |
| Bleeding Disorder | ___ | ___ |
| Basal Cell Carcinoma | ___ | ___ |
| Squamous Cell Carcinoma | ___ | ___ |
| Melanoma | ___ | ___ |

Date: ____________________________

Site: ____________________________

| | YES | NO |
|---|---|---|
| Lupus | ___ | ___ |
| Psoriasis | ___ | ___ |
| Psoriatic Arthritis | ___ | ___ |
| Diabetes | ___ | ___ |
| Hypertension | ___ | ___ |
| Stroke | ___ | ___ |
| Heart Attack | ___ | ___ |
| Hyperthyroidism | ___ | ___ |
| Hypothyroidism | ___ | ___ |
| Parkinsons | ___ | ___ |
| Hepatitis A-B-C | ___ | ___ |
| HIV/AIDS | ___ | ___ |
| Glaucoma | ___ | ___ |
| Tuberculosis | ___ | ___ |
| Pregnant | ___ | ___ |
| Breast Feeding | ___ | ___ |
| Trying to Conceive | ___ | ___ |

**Explain all YES / Additional Information**

__________________________________

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**ALLERGIES** ___NONE

| | | |
|---|---|---|
| Lidocaine | ___ | ___ |
| Epinephrine | ___ | ___ |
| Latex | ___ | ___ |

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## SOCIAL HISTORY

Occupation______________________________

| | | | |
|---|---|---|---|
| Smoking | Never | Past | Present |
| Alcohol | Never | Seldom | Daily |
| Drug Use | Never | Seldom | Daily |

Hobbies________________________________

Sports_________________________________

School Grade ___________________________

Height ________________________________

Weight ________________________________

**MEDICATIONS AND DOSAGE ___NONE**

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**SURGICAL HISTORY ___NONE**

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**FAMILY HISTORY** ___**Adopted**

| | YES | NO |
|---|---|---|
| Melanoma | ___ | ___ |
| Atypical Moles | ___ | ___ |
| Psoriasis | ___ | ___ |
| Asthma | ___ | ___ |
| Allergies | ___ | ___ |
| Eczema | ___ | ___ |
| Lupus | ___ | ___ |

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**PRIMARY CARE PHYSICIAN**

Name: ____________________________

Location: __________________________

__________________________________

Phone: ___________________________

Fax: _____________________________

**PREFERRED LOCAL PHARMACY**

Name: ____________________________

Location: __________________________

Phone: ___________________________

Fax: _____________________________

**PREFERRED MAIL AWAY PHARMACY**

Name: ____________________________

Phone: ___________________________

Fax: _____________________________

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**PERMISSION FOR TREATMENT**

I, the undersigned, hereby voluntarily consent to medical care/diagnostic treatment and minor surgical treatment deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me regarding treatment or examination in the office. I authorize the release of any past/current medical records that are needed for my treatment from prior healthcare providers.

SIGNATURE: ________________________________ Date: ___________________________

PRINT NAME: _______________________________ Provider: _________________________