# INTRACOASTAL DERMATOLOGY MEDICAL HISTORY

Last Name____________________________ First Name____________________________ MI____ DOB_____________

Reason for Visit: ___________________________________________________________________________________

**Past Medical History: (please circle all that apply)**

| | | | |
|---|---|---|---|
| Anxiety | COPD | HIV/AIDS | Stroke |
| Arthritis | Coronary Artery Disease | Hypercholesterolemia (High Cholesterol) | Valve Replacement |
| Artificial joints | Depression | Hyperthyroidism | None |
| Asthma | Diabetes | Hypothyroidism | Other: |
| Atrial fibrillation | End Stage Renal Disease | Leukemia | _________________________ |
| BPH (enlarged prostate) | GERD | Lung Cancer | _________________________ |
| Bone Marrow Transplantation | Hearing loss | Lymphoma | _________________________ |
| Breast Cancer | Hepatitis A B C | Prostate Cancer | _________________ |
| Colon Cancer | Hypertension | Radiation Treatment | |
| | | Seizures | |

**Past Surgical History:** ___________________________________________________________________________

_____________________________________________________________________________________________________

**Skin Disease History: (please circle all that apply)**

| | | | |
|---|---|---|---|
| Acne | Dry Skin | Melanoma | Squamous Cell Skin Cancer |
| Actinic Keratosis (pre-cancer) | Eczema | Poison Ivy | Fever Blisters / Cold Sores |
| Basal Cell Skin Cancer | Flaking or Itchy Scalp | Precancerous Moles | |
| Blistering Sunburns | Hay Fever/Allergies | Psoriasis | |

**Do you wear Sunscreen?** ☐ Yes ☐ No If yes, what SPF? ___________

**Do you tan in a tanning salon?** ☐ Yes ☐ No

**Do you have a family history of Melanoma?** ☐ Yes ☐ No If yes, which relative(s)?

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

**Medications:** (Please enter all current medications **AND DOSES** including vitamins and herbal supplements. If you have a list of your current medications, please provide that to the front desk so they can make a copy for your chart.)

_____________________________________________ _____________________________________________

_____________________________________________ _____________________________________________

_____________________________________________ _____________________________________________

_____________________________________________ _____________________________________________

_____________________________________________ _____________________________________________

**Social History:**

Do you smoke? ☐ Yes ☐ No If yes, packs per day? ________

Alcohol? ☐ Yes ☐ No If yes, how many drinks per day on average? ________________

INTRACOASTAL DERMATOLOGY

**Pharmacy Information:**
Pharmacy Name: ___________________________________ Phone Number: ________________________

Address:_______________________________________________________________________________________

**Medication Allergies:** (Please do not list seasonal allergies.)

______________________________________________________________________________________

______________________________________________________________________________________

Are you allergic to the following? (Leave blank if not allergic) ☐Latex ☐Tape ☐Polysporin ☐Lidocaine

**Current Employer: _____________________________________ Occupation: ____________________________**

**Female Patients:**
Last Menstrual Period ___________________
Are you currently pregnant? ☐Yes ☐No
Are you planning to become pregnant? ☐Yes ☐No

**Review of Systems:**
*Please mark only if you are **currently** experiencing these symptoms*

| | | | **If yes, please comment:** |
|---|---|---|---|
| Problems with bleeding | ☐Yes | ☐No | ___________________________________ |
| Problems with scarring (keloids) | ☐Yes | ☐No | ___________________________________ |
| Rash | ☐Yes | ☐No | ___________________________________ |
| Immunosuppression | ☐Yes | ☐No | ___________________________________ |
| Chest pain | ☐Yes | ☐No | ___________________________________ |
| Fever or chills | ☐Yes | ☐No | ___________________________________ |
| Night sweats | ☐Yes | ☐No | ___________________________________ |
| Unintentional weight loss | ☐Yes | ☐No | ___________________________________ |
| Thyroid problems | ☐Yes | ☐No | ___________________________________ |
| Sore throat | ☐Yes | ☐No | ___________________________________ |
| Blurry vision | ☐Yes | ☐No | ___________________________________ |
| Abdominal pain | ☐Yes | ☐No | ___________________________________ |
| Bloody stool | ☐Yes | ☐No | ___________________________________ |
| Bloody urine | ☐Yes | ☐No | ___________________________________ |
| Joint aches | ☐Yes | ☐No | ___________________________________ |
| Muscle weakness | ☐Yes | ☐No | ___________________________________ |
| Neck stiffness | ☐Yes | ☐No | ___________________________________ |
| Headaches | ☐Yes | ☐No | ___________________________________ |
| Seizures | ☐Yes | ☐No | ___________________________________ |
| Cough | ☐Yes | ☐No | ___________________________________ |
| Shortness of breath | ☐Yes | ☐No | ___________________________________ |
| Anxiety | ☐Yes | ☐No | ___________________________________ |
| Depression | ☐Yes | ☐No | ___________________________________ |
| Pacemaker/Defibrillator | ☐Yes | ☐No | ___________________________________ |

**Patient Signature:** ______________________________________________ **Date:** ________________________