HOLLAND Dermatology

Medical History (06/29/2023 sd)

Barbara S. Drozdowski, MD FAAD

Patient's Name _____ Date of Birth _____

Preferred Pharmacy/Location_____

Have you been diagnosed and/or treated for any of these conditions?
(Please check ALL that apply)

_____Anemia
_____Anxiety
_____Arthritis
_____Asthma
_____Atrial Fibrillation (Irregular Heartbeat)
_____Blood Clots
_____Cancer, please specify:
_____
_____COPD
_____Coronary Artery Disease
_____Depression
_____Diabetes
_____End Stage Renal Disease
_____GERD
_____ Hepatitis
_____ Hypertension (High Blood Pressure)
_____ HIV / AIDS
_____ Hypercholesterolemia
_____ Kidney Disease (Did it require Dialysis Y or N)
_____ Thyroid Disorder (Hyperthyroid / Hypothyroid)
_____ Lymphoma
_____ Seizures
_____ Stroke
_____ Abnormal Immune System
_____ Heart Attack
_____ Peripheral Vascular Disease
_____ Skin Cancer
_____ Melanoma

Have you received a Blood Transfusion?	Y / N
Have you received X-ray Treatments for Acne?	Y / N
Have you received Radiation Treatment for a Cancer?	Y / N
Have you received Light Treatment for any Kind of Skin Condition?	Y / N

Have you had any falls in the past 12 months? Yes / No (circle one)

If yes, did you sustain any injuries? Yes / No (circle one)

Do You? (Please check ALL that apply)

_____ Receives Flu Shots?
_____Receive Allergy Shots?
_____ Have a Pacemaker?
_____ Have an Artificial Heart Valve?
_____ Have an Abnormal Heart Valve?
_____ Require Antibiotics Prior to Dental Procedures?
_____ Develop Rashes or Reactions to: Bandages/Tapes/Antibiotic Ointments?
_____ Receives Pneumonia Shots?
_____ Have Any Organ Transplants?
_____ Have Any Artificial Joints?
_____ Tend to Form Keloid Scars?
_____ Tend to Heal Slowly or Poorly?
_____ Have Varicose Veins?

Do you have any other medical conditions? If yes, please list: _____

_____

Please list all major surgeries _____

_____

Do you wear sunscreen? Y or N (If so, what SPF?_____) Do you use a tanning bed/booth? Y or N

Continued on Back 

Females Only: (if the patient has not undergone changes of puberty, circle n/a) → N/A

Do you develop frequent yeast infections when taking antibiotics?	Y or N
Have you had your uterus removed (hysterectomy)?	Y or N
Have you had your ovaries removed?	Y or N
Are you currently menopausal?	Y or N
Have you had one or more miscarriages?	Y or N

❑ *Attention Nurses:* If checked, medications listed below do not include all previous meds listed in EMA. Please review current meds with patient in the room.

Medication History:

Are you allergic to any medications? Y or N **If yes**, please list:_____

Please list **ALL** medications you are currently taking (prescriptions, over-the-counter meds, vitamins & herbal supplements):

_____

_____

Do you ever take aspirin, ibuprofen (Motrin, Advil) naproxen sodium (Aleve, Naprosyn), vitamin E supplements, garlic, ginger, gingko or ginseng supplements? If yes, please list the items you do take and describe how often. _____

_____

Have you ever had local anesthesia? Y / N Have you ever had a reaction to local or general anesthesia? Y / N

Family History of Melanoma: Do you have any family members (father, mother siblings or child) with melanoma?

Y or N (if yes, who?) _____

Social History:

Do you use tobacco products of any kind? (Currently / Formerly / Never) If currently, list type _____

Amount per day _____

Do you drink alcohol? Y or N If yes, how much? (# of drinks per day) _____

Do you or have you ever used recreational drugs? Y or N If yes, what? _____

Route taken? (Oral, IV, nasal, smoke) _____

Have you ever been exposed to HIV or Hepatitis C? Y or N

When exposed to the sun in the spring *(first significant sun exposure of the warm season*), do you? (Please check one)

____ Burn Only ____ Burn then Tan ____ Tan Only

Signature of Patient _____ Date _____

(Legal Guardian if Patient is a Minor)

IF THIS FORM HAS BEEN COMPLETED PREVIOUSLY – Please review & update then initial & date below

Initial _____ Date _____