



THE CAPITAL DERMATOLOGY MEDICAL GROUP

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MEDICAL HISTORY FORM

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list:
1. _____ 2. _____

List all medications you are currently taking:
1. _____ 3. _____
2. _____ 4. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

LUNGS:	YES	NO	OTHER SYSTEMIC:	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>
			Bowel	<input type="checkbox"/>	<input type="checkbox"/>
VASCULAR:			Hepatitis or Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>			
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>			
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>			

Do you drink alcohol? YES NO If YES, _____ drinks per day
Do you use IV drugs? YES NO If YES, what? _____ How much? _____
Have you had or have you been exposed to HIV (AIDS)? YES NO
Have you ever had dental anesthesia (Novacaine)? YES NO Any bad reaction? YES NO

Skin:

When you are exposed to sun, do you: Tan only Tan and Burn Burn
Have you ever had skin cancer? YES NO
Has anyone in your family had skin cancer? YES NO If YES, what? _____
Do you have a history of any specific skin diseases? YES NO
If yes, please list: _____
List any other disease or condition we should know about: _____
List surgical procedures you have had in the last six months: _____

Please answer the following questions:

- A. Do you smoke? YES NO If YES, how much? _____
- B. Do you bleed easily? YES NO
- C. (Women) Are you pregnant? YES NO Due date: _____
- D. Do you have artificial joint(s)? YES NO
- E. What is your occupation? _____
- F. What are your hobbies? _____

Completed by: Patient _____
 Medical Assistant _____
Initials

Signed by Physician _____ Date _____