

PATIENT MEDICAL HISTORY FORM

Dermatology Center of Loudoun, PLC

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This form is a part of your permanent medical record. Thank you for taking the time to complete it as thoroughly and accurately as possible.

NAME (Last, First, MI) _____

DATE OF VISIT _____

REASON(S) FOR TODAY'S VISIT (Please limit to 3 complaints)

1. _____
2. _____
3. _____

I would like to discuss treatment options for the following cosmetic issues :

wrinkles sun damage/sunspots hair removal spider veins/broken blood vessels uneven skin texture/tone

MEDICATIONS

Please list all current medications, including topical creams, vitamins, OTC's, and herbal supplements:

MEDICAL HISTORY

Please list all current/chronic medical conditions:

1. _____
2. _____
3. _____
4. _____
5. _____

Have you ever had skin cancer or atypical moles? **YES** **NO**

If yes, what type _____

Do you require antibiotics prior to surgery or dental work? **YES** **NO**

Are you nursing?	YES	NO
Are you pregnant?	YES	NO
If yes, due date _____		
Are you trying to get pregnant?	YES	NO

ALLERGIES

Please list any known drug allergies:

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Are you allergic to latex?	YES	NO
Are you allergic to any local anesthetics?	YES	NO

FAMILY HISTORY

Please list any medical conditions (including but not limited to skin conditions, such as non-melanoma and melanoma skin cancers, psoriasis, eczema) of the following family members:

Father	_____
Mother	_____
Siblings	_____
Children	_____
Paternal Grandfather	_____
Paternal Grandmother	_____
Maternal Grandfather	_____
Maternal Grandmother	_____

SOCIAL HISTORY

Please be honest. This can affect medication selection and dosing.

Do you smoke?	YES	NO
If yes, how often and how much?	_____	

Do you drink alcohol?	YES	NO
If yes, how often and how much?	_____	

Do you use recreational drugs?	YES	NO
If yes, how often and how much?	_____	

Do you use sunscreen?	YES	SOMETIMES	NO
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Do you have a history of extensive sun exposure or blistering sunburns?	YES	NO
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Do you have a history of tanning bed use?	YES	NO
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What is your occupation? _____

REVIEW OF SYMPTOMS

Please check any of the following that you have experienced in the past 6 months:

<p>GENERAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> weight gain / loss <input type="checkbox"/> loss of appetite <input type="checkbox"/> fever / chills <input type="checkbox"/> weakness <input type="checkbox"/> night sweats <p>DERMATOLOGY</p> <ul style="list-style-type: none"> <input type="checkbox"/> rash <input type="checkbox"/> lumps <input type="checkbox"/> dry/sensitive skin <input type="checkbox"/> hives <input type="checkbox"/> suspicious moles <input type="checkbox"/> suspicious lesions <input type="checkbox"/> jaundice <input type="checkbox"/> acne <input type="checkbox"/> itching <input type="checkbox"/> hair loss <p>EAR/NOSE/THROAT</p> <ul style="list-style-type: none"> <input type="checkbox"/> congestion <input type="checkbox"/> nosebleed <input type="checkbox"/> change in voice <input type="checkbox"/> sore throat <input type="checkbox"/> difficulty swallowing 	<p>ALLERGY</p> <ul style="list-style-type: none"> <input type="checkbox"/> runny nose <input type="checkbox"/> scratchy throat <input type="checkbox"/> itchy eyes <input type="checkbox"/> sinus congestion <input type="checkbox"/> sneezing <p>CARDIOLOGY</p> <ul style="list-style-type: none"> <input type="checkbox"/> chest pain <input type="checkbox"/> palpitations <input type="checkbox"/> leg swelling <p>MUSCULOSKELETAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> joint stiffness <input type="checkbox"/> leg cramps <input type="checkbox"/> joint pain <input type="checkbox"/> joint swelling <input type="checkbox"/> back pain <input type="checkbox"/> neck pain <input type="checkbox"/> muscle aches <p>RESPIRATORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> shortness of breath <input type="checkbox"/> chest tightness <input type="checkbox"/> cough <input type="checkbox"/> wheezing <input type="checkbox"/> congestion 	<p>PSYCHOLOGY</p> <ul style="list-style-type: none"> <input type="checkbox"/> depression <input type="checkbox"/> high stress level <input type="checkbox"/> suicidal thinking <input type="checkbox"/> eating disorder <input type="checkbox"/> mental or physical abuse <input type="checkbox"/> mood swings <input type="checkbox"/> obsessive - compulsive tendencies <p>ENDOCRINE</p> <ul style="list-style-type: none"> <input type="checkbox"/> excessive sweating <input type="checkbox"/> excessive thirst <input type="checkbox"/> excessive urination <input type="checkbox"/> heat intolerance <input type="checkbox"/> cold intolerance <p>BLOOD/LYMPH</p> <ul style="list-style-type: none"> <input type="checkbox"/> swollen glands <input type="checkbox"/> fatigue <input type="checkbox"/> varicose veins <input type="checkbox"/> easy bruising 	<p>OPHTHALMOLOGY</p> <ul style="list-style-type: none"> <input type="checkbox"/> decreased vision <input type="checkbox"/> eye irritation <input type="checkbox"/> eye drainage <input type="checkbox"/> blurry vision <p>NEUROLOGY</p> <ul style="list-style-type: none"> <input type="checkbox"/> headache <input type="checkbox"/> tingling/numbness <input type="checkbox"/> seizures <input type="checkbox"/> dizziness <p>GASTROENTEROLOGY</p> <ul style="list-style-type: none"> <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> heartburn <input type="checkbox"/> abdominal pain <input type="checkbox"/> change in bowel habits <p>UROLOGY</p> <ul style="list-style-type: none"> <input type="checkbox"/> difficulty urinating <input type="checkbox"/> blood in urine <input type="checkbox"/> leaking urine
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Patient Signature _____

Date _____