

# 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 FOR VISIT** \_\_\_\_\_

- 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 medical conditions**:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

- |   |            |           |
|---|------------|-----------|
| Have you ever had skin cancer or atypical moles?            | <b>YES</b> | <b>NO</b> |
| If yes, what type _____                                     |            |           |
| Do you require antibiotics prior to surgery or dental work? | <b>YES</b> | <b>NO</b> |
| Are you nursing?  | <b>YES</b> | <b>NO</b> |
| Are you pregnant?   | <b>YES</b> | <b>NO</b> |
| If yes, due date _____                                      |            |           |
| Are you trying to get pregnant?                             | <b>YES</b> | <b>NO</b> |

**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**

Do you have a history of extensive sun exposure or blistering sunburns? **YES NO**

Do you have a history of tanning bed use? **YES NO**

What is your occupation? \_\_\_\_\_

## REVIEW OF SYMPTOMS

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

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

Date \_\_\_\_\_