

**Elizabeth Anderson, MD Dermatology**  
**Patient History**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Address: \_\_\_\_\_

Pharmacy and Location: \_\_\_\_\_

Chief Complaint (the skin problem that brought you to the office):

\_\_\_\_\_

\_\_\_\_\_

Have you had any treatment for these problems previously?  Yes  No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever had an allergic reaction to dental anesthesia (novocaine)?  Yes  No

Allergies to medications: \_\_\_\_\_

Current medication(s) and supplements:

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

ARE YOU TAKING ASPIRIN OR ANY OTHER BLOOD THINNER?  Yes  No

If yes, please list:  Aspirin  Coumadin  Plavix  Other: \_\_\_\_\_

**Skin History:**

Have you ever had skin cancer?  Yes  No If yes, what type have you had?

Basal Cell  Squamous Cell  Melanoma  Actinic Keratosis or Pre-Cancers

Do you have?  Psoriasis  Excessive Scarring  Eczema

When you are exposed to the sun do you?:  Tan Only  Tan and Burn  Burn

Do you have a history of a specific skin disease?  Yes  No

If yes please list: \_\_\_\_\_

**Family History ( Please indicate any conditions present in immediate family):**

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Melanoma _____  | <input type="checkbox"/> Lupus_____  |
| <input type="checkbox"/> Eczema _____    | <input type="checkbox"/> Cancer_____ |
| <input type="checkbox"/> Psoriasis _____ | <input type="checkbox"/> Other_____  |

**Review of Systems/Medical History: Have you ever had**

**CARDIOVASCULAR**

- |                      |  |
|----------------------|--|
| Heart attack         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart failure (CHF)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Irregular Heart Beat | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**HEMATOLOGY**

- |                   |  |
|-------------------|--|
| Anemia            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood clot        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleed easily      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lymphoma/Leukemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HIV               | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**NEUROLOGIC**

- |              |  |
|--------------|--|
| Stroke       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Seizures     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Paralysis    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lyme Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye trouble  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**GENITOURINARY**

- |                        |  |
|------------------------|--|
| Kidney Trouble         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Irregular Menstruation | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| STD                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**PULMONARY**

- |                   |  |
|-------------------|--|
| Asthma/Emphysema  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pneumonia         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tuberculosis (TB) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sarcoidosis       | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**ENDOCRINE**

- |                 |  |
|-----------------|--|
| Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes        | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**PSYCHIATRIC**

- |                           |  |
|---------------------------|--|
| Depression                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other psychiatric disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**GASTROENTEROLOGY**

- |                  |  |
|------------------|--|
| Stomach trouble  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bowel trouble    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver Disease    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**RHEUMATOLOGY**

- |              |  |
|--------------|--|
| Arthritis    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lupus        | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Have you had an organ transplant?  Yes  No If yes, what type? \_\_\_\_\_

Have you had a heart valve replacement?  Yes  No If yes, what type? \_\_\_\_\_

Do you have a heart valve abnormality?  Yes  No

Do you take antibiotics prior to dental procedures?  Yes  No

Have you had a joint replacement (knee, hip, etc.)?  Yes  No

Do you have a pacemaker or defibrillator?  Yes  No

Have you had any major operations, hospitalizations, or illnesses?  Yes  No

If yes, please describe: \_\_\_\_\_

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Are you pregnant?  Yes  No If yes, due date: \_\_\_\_\_

Are you breastfeeding?  Yes  No

Date of last menstrual period? \_\_\_\_\_

**Social History:**

Educational Level: \_\_\_\_\_

Do you: Drink alcohol?  Yes  No Drinks per day? \_\_\_\_\_

Exercise regularly?  Yes  No

Smoke?  Yes  No Packs per day? \_\_\_\_\_

Use illicit drugs?  Yes  No

Sunbathe or use a tanning bed?  Yes  No

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**Patient or Guardian Signature**

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**Date**

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**Physician Signature**

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**Date**