Date:_____

DERMATOLOGY NORTHWEST, LLC

Name:_____ DOB:_____ Referred by:_____

Are you allergic to any medications?
1._____ 2._____ 3._____

Where did you grow up?_____

MEDICAL HISTORY: Do you or have you had any of the following?

Constitutional	Present	Past
Chills		
Fatigue		
Fever		
Weakness		
Weight Gain		
Weight Loss		

Skin	Present	Past
Blistering		
Bruising		
Burning		
Cold Sores		
Dry Lips		
Dry Skin		
Acne		
Folliculitis		
Itching		
Nail Changes		
New lesions/growths		
Peeling Feet		
Photosensitivity		
Pigment changes		
Rash		
Rosacea		
Eczema		
Skin nodules		
Thinning hair		
Psorasis		
Contact allergies		
Vitiligo		

Respiratory	Present	Past
Cough		
Shortness of Breath		
Asthma		
Wheezing		
Hx of Tuberculosis		

Cardiovascular	Present	Past
Chest Pain		
Edema		
Irregular heart beat		
Congestive heart failure		
Pacemaker		
High blood pressure		
Heart murmur		

Vascular	Present	Past
Raynaud's		
Varicose veins		

Neurologic/Psychiatric	Present	Past
Anxiety		
Depressed Mood		
Memory distrubance		
Paralysis		
Abnormal sensation		
Seizure like activity		
Self consciousness		
Suicide ideation		
Fainting		

HEENT	Present	Past
Blurred Vision		
Burning Eyes		
Decreased night vision		
Dry Eyes		
Nose bleeds		
Glaucoma		
Mouth ulcers		
Sore throat		
Styes		
Tearing		
Vision changes		

Metabolic/Endocrine	Present	Past
Diabetes		
Thyroid abnormalities		
Excessive hair		

Musculoskeletal	Present	Past
Arthritis		
Rheumatoid arthritis		
Muscle weakness		
Muscle pain		

Hematologic	Present	Past
Abnormal bleeding		
Anemia		
Blood clots		
Easy bleeding		
Easy bruising		
Enlarged lymph nodes		
Lymphoma		

Immunological	Present	Past
Hives		
Food allergies		
Frequent infections		
Evironmental allergies		
Lupus - Scleroderma		
Other significant condition		

PLEASE SEE BACK

Gastrointestinal	Present	Past
Abdominal pain		
Heartburn		
Nausea		

Gastrointestinal	Present	Past
Diarrhea		
Hx of Hepatitis		
Vomitting		

Genitourinary	Present	Past
Dark urine		
Painful urination		

Gender specific	Present	Past
Abnormal menses		
Yeast infection		
Planning pregnancy		
Pregnant		
Hx of STD's		

Family History	Family Member (maternal/paternal)	Self
Cancer		
Skin cancer		
Diabetes		
Psoriasis		
Eczema		

Please list prior surgeries	Date
1	
2	
3	
4	
5	

Habits	Yes		Yes		Yes
Alcohol		Protective sun wear		Skin self examination	
Smoking		Sunglasses-Hat		Regular use of sunscreen	
Blistering sunburns		Tanning beds		SPF level	
in the past?					

Current Medications

Medication	Dosage	Times per day
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		