AMY A VAUGHAN DERMATOLOGY PLLC
Dermatology Medical History

Patient: ____ **Today's Date**: ___/___/______

DOB: ____________________ Male______ Female______

Are you **ALLERGIC to any medications**? ☐ YES ☐ NO If yes, please list below:

1. _____________________Reaction:______________ 2. _____________________Reaction:______________

List all **MEDICATIONS** you are currently taking (including prescriptions, over-the-counter meds, vitamins and herbals):

1.___________________________ 3.___________________________ 5. ____________________________

2.___________________________ 4.___________________________ 6.____________________________

7.___________________________ 8.___________________________ 9.____________________________

Current Local Pharmacy ___________________________ **Mail Order Pharmacy**____________________________

MEDICAL HISTORY:

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

	Yes	No		Yes	No
Anxiety	☐	☐	Hearing Loss	☐	☐
Arthritis	☐	☐	Artificial Heart Valve	☐	☐
Artificial Joint	☐	☐	Hepatitis	☐	☐
(**if yes**, which joint_____________					
Asthma	☐	☐	HSV (fever blister)	☐	☐
Atrial Fibrillation	☐	☐	High Blood Pressure	☐	☐
Blood Thinner	☐	☐	HIV/AIDS	☐	☐
Bone Marrow Transplant	☐	☐	High Cholesterol	☐	☐
Benign Prostatic Hypertrophy	☐	☐	Hyperthyroidism	☐	☐
Breast Cancer	☐	☐	Hypothyroidism	☐	☐
Colon Cancer	☐	☐	Leukemia	☐	☐
COPD	☐	☐	Lung Cancer	☐	☐
Coronary Artery Disease	☐	☐	Lymphoma	☐	☐
Depression	☐	☐	Prostate Cancer	☐	☐
Diabetes	☐	☐	Radiation Treatment	☐	☐
End Stage Renal Disease	☐	☐	Seizures	☐	☐
GERD	☐	☐	Stroke	☐	☐

List any other diseases or conditions: ____

List surgical procedures you have had in the last 6 months: ____

(Women) Last Menstrual Period ____/____/______

Are you pregnant? ☐ YES ☐ NO Due Date: ____/____/_____

Are you breastfeeding? ☐ YES ☐ NO

SKIN HISTORY:

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

	Yes	No		Yes	No
Acne	☐	☐	Hay Fever/Allergies	☐	☐
Actinic Keratosis	☐	☐	Melanoma	☐	☐
Basal Cell Carcinoma	☐	☐	Poison Ivy	☐	☐
Blistering Sunburn	☐	☐	Precancerous Moles	☐	☐
Dry Skin	☐	☐	Psoriasis	☐	☐
Eczema	☐	☐	Squamous Carcinoma	☐	☐
Flaking or Itchy Scalp	☐	☐			

Other: ____

(Please complete back of this form)

Dermatology Medical History

Has anyone in your family had melanoma? ☐ YES ☐ NO If yes, who?____
Do you have a family history of any skin cancer? ☐ YES ☐ NO If yes, what type? ______________________________
Do you wear sunscreen? ☐ YES ☐ NO If yes, what SPF?___________________________
Do you tan in a tanning salon? ☐ YES ☐ NO
Do you have problems with healing? ☐ YES ☐ NO
Do you bleed easily? ☐ YES ☐ NO
Do you develop skin rashes in reaction to ☐ Adhesives ☐ Topical Antibiotic Ointment ☐ Environment ☐ Food ______
☐ Latex ☐ Other _________________

SOCIAL HISTORY:
Tobacco Use -
Are you now or have you ever smoked? Never Smoker______ Former Smoker______ Current Smoker______
If Current Smoker, how much _______________________________

Do you drink alcohol? Yes _______ No______ (if Yes, _______ drinks per day)
Do you use IV drugs? Yes______ No_______ (if Yes, what? _______, How often?________)

Have you received your pneumonia vaccine? Yes______ No______
Have you received your flu vaccination this year? Yes______ No______

ALERTS:
Do you have an allergy to Lidocaine? ☐ YES ☐ NO
Do you have an allergy to Epinephrine? ☐ YES ☐ NO
Do you have a history of MRSA infection? ☐ YES ☐ NO
Do you have a Pacemaker or Defibrillator? ☐ YES ☐ NO
Currently taking blood thinners or aspirin? ☐ YES ☐ NO
Need antibiotics prior to dental procedures? ☐ YES ☐ NO
Artificial Heart Valve? ☐ YES ☐ NO
Artificial Joint? ☐ YES ☐ NO
History of HIV/AIDS? ☐ YES ☐ NO
Hepatitis B or C? ☐ YES ☐ NO
Active TB? ☐ YES ☐ NO
Convulsions, Epilepsy, Seizures or Fainting? ☐ YES ☐ NO
Fever Blisters? ☐ YES ☐ NO
Keloids (raised scars)? ☐ YES ☐ NO

Would you be interested in discussing? ☐ Botox ☐ Fillers ☐ Laser ☐ Coolsculpting ☐ Skin Care Regimens
☐ Ultherapy ☐ Other ___________________________________

____ ____/____/______
Signed by Patient or Guardian Date