Bryn Mawr Medical Specialists Association

Dermatology Associates

Medical History Questionnaire

Name _____

Date of Birth _____ Age_____

Reason for today's visit _____

Who is your primary care physician? _____

Who referred you to our office? _____ ☐ Physician
☐ Family
☐ Friend

Medication History:

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list _____

_____

Please list all medications you are currently taking. Please include prescriptions, any over-the-counter medications, vitamins or herbal supplements.

Medication	Dose	Frequency	Reason

Do you take Aspirin, Ibuprofen (such as Advil, Aleve or Motrin) or other pain relievers?

☐ Yes ☐ No (Please list above)

Have you ever had dental anesthesia (Novocain)? ☐Yes ☐ No

Did you have any bad reaction to the anesthesia (Novocain)? ☐Yes ☐ No

If yes, what was the reaction? _____

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Medical History:

Do you have any of the following medical conditions? (Please circle)

Arthritis	Heart Murmur
Asthma	Hepatitis
Bleeding Disorder	Elevated Blood Pressure
Bowel Problems	Hives
Breast Cancer	Kidney Stones
Cancer	Seasonal Allergies
Chest Pains/Tightness	Stroke
Diabetes	Thyroid Disorder
Eczema	Tuberculosis
Elevated Cholesterol	Ulcers
Heart Disease	Xray Therapy
Irregular Heartbeat	HIV/AIDS

Any other conditions we should know about? _____

_____

Females:

Are you pregnant? □Yes □ No If yes, what is your delivery date? _____

Are you menstrual periods regular? □Yes □ No □ Post Menopause

Surgical History:

Do you have any of the following?

□ Heart Valve Replacement When? _____

□ Pacemaker When? _____

□ Joint Replacement When? _____ Which joint? _____

List any surgical procedures in the last six months:

_____

Skin History:

Do you have a history of any skin diseases? □Yes □ No

If so, please list: _____

Have you ever had skin cancer? □Yes □ No

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If yes, which type? Where was it located?

☐ Basal cell carcinoma

_____

☐ Squamous cell carcinoma

_____

☐ Malignant Melanoma

_____

What happens when you are exposed to the sun without sunscreen, do you?

☐ Burn Only ☐ Burn, then tan ☐ Tan Only

Family History:

Has anyone in your family been diagnosed with the following:

		If so, whom?
Autoimmune Disease	☐Yes ☐ No	_____
Malignant Melanoma	☐Yes ☐ No	_____
Skin Cancer	☐Yes ☐ No	_____
Psoriasis	☐Yes ☐ No	_____

Social History:

Do you drink alcohol? ☐Yes ☐ No If yes, how much? ☐ Socially ☐ Daily

Which best describes your smoking habits?

☐ Current every day smoker ☐ Current some day smoker

☐ Former Smoker ☐ Never smoked ☐ Unknown if smoked

What is/was your occupation? _____

Reviewed by Provider: _____ Date: _____