Precision Dermatology
History (Medical, Social, Family) and Medication

Patient Name: _____
Date of Birth: _____

Have you any past or present:

	Yes	No
Heart Disease, such as:		
Heart attack	____	____
Dates:	____	____
Angina/chest pain	____	____
Abnormal rhythm	____	____
Coronary disease	____	____
High blood pressure	____	____
CHF	____	____
Pacemaker	____	____
Implantable defibrillator	____	____
Heart valve	____	____
Lung Disease, such as:		
Asthma/wheezing	____	____
Emphysema	____	____
TB (or family hx)	____	____
Shortness of breath	____	____
Sleep Apnea	____	____
Genital/Urinary		
Kidney disease	____	____
Dialysis	____	____
Skin		
Squamous Cell carcinoma	____	____
Basal Cell carcinoma	____	____
Personal hx of Melanoma	____	____
Family hx of Melanoma	____	____
Joints		
Prothesis	____	____
Type _____		
Reproductive		
Are you or might you be pregnant?	____	____
Gastrointestinal		
Liver Disease	____	____
Endocrine		
Diabetes	____	____
Insulin	____	____
Thyroid Disease	____	____

	Yes	No
Blood & Coagulation		
AIDS/HIV	____	____
Hepatitis	____	____
Type _____		
Anemia	____	____
Problems bleeding after surgery	____	____
Blood clots	____	____
Nervous System		
Strokes	____	____
Seizures/ Epilepsy	____	____
Immune System		
Autoimmune disease	____	____
Type _____		
Lymphoma/Leukemia	____	____
Organ transplant	____	____
Smoker	____	____
Packs per day		
# of years		
Have you or anyone in your family had high fever/complications during or after surgery?	____	____
If yes, reaction: _____		
Dentures	____	____
Type _____		
Contact lenses	____	____
Oxygen	____	____
Hearing aids	____	____

Any other conditions you have that are not listed?

_____
_____
_____
_____
_____
_____
_____
_____

Drug Allergies/reactions

_____
_____
_____
_____

Vitamins/Herbal supplements

- ☐ Multivitamin
- ☐ Vitamin D
- ☐ Vitamin E
- ☐ Garlic tablet
- ☐ Aspirin
- ☐ Other

Prescription Meds/mg's

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Reviewed/Updated with patient	
Date	Initials