Dermatology Associates of Glastonbury, LLC

Medical History

Name:_____ **Date:**_____

1. What is the reason for your visit today? _____

2. History of your present problem (answer all those that apply to your problem):
   a. Where is the problem located? _____
   b. What symptoms are present (for example: itching, pain, change in color or size of a growth)? _____
   c. When did the problem begin and how long has it been present? _____
   d. What if anything makes this better or worse? _____
   e. Has the problem been treated (if so, please describe): _____
   f. Have you noted any associated signs or symptoms with your problem? _____

MEDICATIONS

Do you routinely take any **prophylactic antibiotics** prior to surgery or dental work? _____

Do you take any medications that can cause increased bleeding (eg: aspirin, coumadin, non-steroidal anti-inflammatory drugs such as Advil, Motrin or Aleve)? _____

Please list all the medications you currently take. Be sure to include any "over -the-counter" medications (eg., aspirin, tylenol, cold medications, laxatives): _____

Date Began	Medication	Reason for Medication

ALLERGIES TO MEDICATIONS

Please indicate **allergies** you have to any oral or topical (eg., topical antibiotic) medications:

Medication	Nature of Reaction

YOUR PAST MEDICAL HISTORY

Please indicate any of the following conditions you have now or have ever had:

☐	Allergies (asthma, hay fever)	☐	Nephritis, kidney stones	☐	Epilepsy, migraine headaches
☐	Bronchitis, pneumonia, pleurisy	☐	Immune deficiency or AIDS	☐	Glaucoma, iritis, or cataracts
☐	Emphysema	☐	Stroke	☐	Arthritis, gout, or rheumatism
☐	Tuberculosis	☐	Phlebitis/Blood clots	☐	Venereal disease (eg., syphilis, herpes)
☐	High blood pressure	☐	Cancer or a malignancy	☐	Thyroid disorder
☐	Heart murmur	☐	Anemia or bleeding tendency	☐	Positive HIV test
☐	Any other kind of heart trouble	☐	Exposure to X-ray therapy	☐	Severe or blistering sunburn
☐	Liver disease, hepatitis, or jaundice	☐	Ulcers, gallbladder trouble, or colitis	☐	Other
☐	Rheumatic fever	☐	Diabetes ("sugar")		

HOSPITALIZATIONS/OPERATIONS

Please indicate the dates and reasons for any hospitalizations/operations you have had:

Date	Reason for Hospitalization/Operation

FAMILY HISTORY

For yourself as well as other members of your family, please complete the following:

Is There a History of...?	In Whom (You or a Family Member)?
Eczema, Hay Fever, or Asthma	
Psoriasis	
Skin Cancer	
"Funny" Moles	
Melanoma	
Similar condition for which you are being seen today	
Other illness (please specify)	

SYSTEMS REVIEW

Is there anything else in your history that you feel would be important for us to know?: _____

_____

_____

As you review the following list, please check any of those problems which apply to you:

General
____Recent weight gain
____Recent weight loss
____Fatigue
____Weakness
____Fever
____Decline in general health

Eyes
____Pain
____Redness
____Loss of vision
____Double or blurred vision
____Dryness
____Feels like something in eye
____Glaucoma
____Cataracts

Ears
____Ringing in ears
____Loss of hearing

Nose
____Nosebleeds
____Loss of smell
____Dryness
____Nasal stuffiness
____Post nasal drip

Throat
____Frequent sore throats
____Hoarseness
____Difficulty in swallowing

Mouth
____Sore tongue
____Bleeding gums
____Sores in mouth
____Loss of taste
____Dryness

Neck
____Tender glands
____Swollen glands
____Thyroid problem

Heart and Lungs:
____Pain in chest
____Irregular heart beat
____Sudden changes in heart beat
____Shortness of breath
____Difficulty breathing at night
____Swollen legs or feet
____High blood pressure
____Heart murmurs
____Cough
____Coughing of blood
____Wheezing
____Night sweats

Stomach and Intestines
____Nausea
____Vomiting
____Stomach pain relieved by food
____Yellow jaundice
____Increasing constipation
____Persistent diarrhea
____Blood in stools
____Black stools
____Heartburn
____Hemorrhoids
____Painful bowel movements

Kidneys and Genitals
____Difficult urination
____Pain or burning urination
____Blood in urine
____Pus in urine
____Cloudy, "smoky" urine
____Penile or vaginal discharge
____Frequent urination
____Kidney stones
____Prostate trouble
____Vaginal dryness
____Genital rash or ulcers

Muscles and Joints
____Muscle weakness
____Muscle tenderness
____Joint pain
____Joint swelling

Blood:
____Anemia
____Bleeding tendency

Gynecologic
____Irregular menstrual periods
____Hot flashes
____Abortion or miscarriage
____Breast lump or mass
____Nipple discharge
____Pain or bleeding after sex
____**Pregnant** (if yes, # of weeks _____)
____Trying to become pregnant
____**Breast feeding**
____Do you use birth control?
_____ Yes _____ No
If yes, what type _____
Date of last PAP smear _____

Social History
Do you smoke? _____ Yes _____ No
Cigarettes per day? _____

What alcoholic beverage do you drink in an average week:
Type _____
Amount _____

Do you use drugs for recreational purposes?
_____ Yes _____ No

Do you exercise regularly?
_____ Yes _____ No

Your occupation:
_____
_____

Hobbies:
_____
_____

Recent travel:
_____
_____

Do you wear sunscreen?
_____ Yes _____ No
SPF Number? _____

Patient Signature:_____

Physician Review (Do not write in this area) _____

Date: _____

_____

_____