Dermatology History Checklist

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You can complete this form by tabbing through the fields in Microsoft Word, or by printing out the form and hand-writing your information. If you have a question while completing the form in Word, simply hover over the field in question and press the F1 key on your keyboard for pop-up assistance.

Patient: __________________________________________ Date: _______________________

Chief Complaint: _____________________________________________________________

Have you had any treatment for these problems?  □ Yes  □ No
If yes, please describe: ________________________________________________________

Please list any Allergies to medications: _________________________________________

Please list your current medication(s):
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Have you had any major operations or illnesses in the past?  □ Yes  □ No
If yes, please describe: ________________________________________________________

Medical History: Please check if you have had any of the following symptoms or diseases:
□ HIV/AIDS  □ Cataracts  □ Anemia  □ Asthma
□ Hypertension  □ Cancer  □ Heart Disease  □ Diabetes
□ Thyroid Disease  □ Phlebitis  □ Seizures  □ Stroke
□ Peptic Ulcer Disease  □ Arthritis  □ Jaundice  □ Hepatitis
□ Chest Pain  □ Heart Attack  □ Irregular Heartbeat  □ Pacemaker
□ Alcohol Problems  □ Fainting  □ Other: _______________________________________

Skin History:
When you are exposed to the sun do you: □ Tan Only  □ Tan and Burn  □ Burn
Have you ever had skin cancer?  □ Yes  □ No
If yes, what type have you had?  □ Basal Cell  □ Squamous Cell  □ Melanoma
Has anyone in your family had skin cancer?  □ Yes  □ No
Do you have a history of a specific skin disease?  □ Yes  □ No
If yes please list: ____________________________________________________________

Please check if you have had any of the following skin problems:
□ Eczema  □ Psoriasis  □ Actinic Keratosis or Pre-Cancers
□ Excessive Scarring  □ Frequent Sun Exposure  □ Non-healing or bleeding growths

Please answer the following questions:
Do you smoke?  □ Yes  □ No  If yes, how much? ___________________________________
Do you bleed easily?  □ Yes  □ No
Are you pregnant?  □ Yes  □ No  If yes, due date: _______________________________
DO YOU HAVE A SURGICALLY IMPLANTED DEFIBRILLATOR?  □ Yes  □ No

Signature  Patient  Nurse  Reviewed by – Signature of Doctor