Dermatology History Checklist

John L. Meisenheimer, M.D.
407-352-2444

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