



MAHONEY
DERMATOLOGY SPECIALISTS, P.A.

Dermatology Medical History

Patient: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Reason for visit today: _____

Are you allergic to any medications? YES NO If yes, list below:

1. _____ 2. _____ 3. _____

Have you ever had dental anesthesia (Novocaine)? YES NO Any adverse reaction? YES NO

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Lungs:			Other Systemic:		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:			Gastrointestinal		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizure, Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: _____

List surgical procedures you have had in the last 10 years: _____

Have you had any previous hospitalizations?: _____

Skin: Have you ever had skin cancer? YES NO If YES, _____
 Has anyone in your family had skin cancer? YES NO If YES, _____
 Do you have a history of any specific skin diseases? YES NO If YES, _____
 Do you have problems with healing YES NO
 Do you develop keloids (scars) after surgery YES NO
 Do you develop skin rashes in reaction to: Medications Food Environment Bandages Topical Neosporin
 Other _____

Please answer the following:

Do you drink alcohol? YES NO If YES _____ drinks/day Do you smoke? YES NO If YES _____ packs/day

Do you have or have you been exposed to HIV (AIDS)? YES NO

(Women) Are you pregnant? YES NO Due Date: ____/____/____ Are you breastfeeding? YES NO

Other Skin Care Interests (please check all that apply):

- Acne
- Sun Damage
- Excess Sweating
- Sunscreen Advice
- Birthmarks/Moles
- Chemical Peels
- Laser Treatments
- Skin Care Advice
- Skin Care Products
- Skin Rejuvenation
- Liver/Age Spots
- Latisse
- Obagi
- Botox
- Juvederm
- Hair Loss
- Hair Removal
- Other: _____

Primary Care Physician: _____ How did you hear about us?: _____

Patient or Guardian Signature: _____ Date: ____/____/____

Updated Signature: _____ Updated Date: ____/____/____

(Do not sign at initial visit, for future use only)