Germain Dermatology Medical History

Patient: _____ Date of Birth: ____/_____/_____ Chart#: _____

Do you have now or have you ever had any of the following past medical history?

	Y	N		Y	N		Y	N
Abnormal Bleeding/Bleeding Disorder	□	□	Heart Murmur	□	□	Seizures/Fainting/Epilepsy	□	□
Alcohol/Drug Dependency	□	□	Hepatitis B or C-	□	□	***Please specify_____**		
Anxiety/History of Anxiety	□	□	***Please Specify_____**			Stomach Issues/Crohn's/	□	□
Arthritis/Joint Pain	□	□	High Blood Pressure	□	□	IBS/GERD		
Asthma	□	□	High Cholesterol	□	□	***Please specify_____**		
Cancer (**what type**) _____	□	□	HIV/AIDS	□	□	ADHD	□	□
Defibrillator	□	□	Kidney Disease	□	□	Thyroid Disorder	□	□
Depression/History of	□	□	Liver Disease	□	□	Tuberculosis/History of TB	□	□
Diabetes	□	□	Lupus/SLE	□	□	Other Medical Condition	□	□
Glaucoma	□	□	Mitral Valve Prolapse	□	□	***Please Specify_____**		
Hay Fever/Allergies	□	□	Multiple Sclerosis	□	□			
Hernia	□	□	Pacemaker	□	□			
Heart Attack/Heart Disease	□	□	Stroke	□	□			

Do you have now or have you ever had any of the following past medical skin history?

	Y	N		Y	N
Acne	□	□	Actinic Keratosis (pre-cancerous lesion (s))	□	□
Eczema	□	□	Biopsy Proven Atypical/ Dysplastic Mole	□	□
Fever Blisters/Cold Sores/Herpes Simplex	□	□	Proven Skin Cancer-Unknown Type	□	□
Keloid(s)/Scars/Healing Problems	□	□	Melanoma	□	□
Skin Allergies/Sensitive Skin	□	□	Basal Cell Carcinoma	□	□
Psoriasis	□	□	Squamous Cell Carcinoma	□	□
Rosacea	□	□			

Do you have a family history of the following?

	Y	N		Y	N		Y	N
Acne	□	□	Endocrine Disease	□	□	Psoriasis	□	□
Abnormal Bleeding/Hemophilia	□	□	Heart Disease	□	□	Skin Disease	□	□
Autoimmune Disorders	□	□	High Blood Pressure	□	□	***Please Specify_____**		
Cancer	□	□	Hemophilia	□	□	Skin Cancer- Melanoma	□	□
Diabetes	□	□	Kidney Disease	□	□	Skin Cancer- Basal Cell	□	□
Eczema	□	□	Liver Disease	□	□	Skin Cancer- Squamous Cell	□	□
						Skin Cancer-Type Unknown	□	□

Please list all previous surgeries and dates:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Are you allergic to any medications? □ y □ n **If yes, list below:**

1._____2._____3._____

Please list all current medications and dosage (ie: prescriptions, acne medications, OTC medications, and vitamins):

1._____2._____3._____

4._____5._____6._____

Are you allergic to any of the following?

Local Anesthetic (lidocaine) □ y □ n Latex □ y □ n Adhesive Tape □ y □ n

Social History

Do you use illegal drugs? □y □n

Do you drink alcohol? □y □n

If YES:

1. How <u>often</u> do you have a drink containing alcohol?
   - □Monthly or less often □2 to 4 times per month
   - □2 to 3 times per week □4 or more times per week

2. How <u>many</u> drinks do you have on a typical day when you are drinking?
   - □Less than 2 □3 or 4
   - □5 or 6 □7 to 9
   - □10 or more

3. How often do you have 6 or more drinks?
   - □Never □Less than monthly
   - □Weekly □Daily or almost daily

Smoking History

□Current every day smoker □Former smoker

□Current some day smoker □Never smoker

FEMALE PATIENTS ONLY

Are you pregnant? □ y □ n

Are you nursing? □ y □ n

Are you trying to become pregnant? □ y □ n

Type of Contraception (please choose at least one option):

Trying to get pregnant	□	IUD	□
Abstinence (not sexually active)	□	Oral Contraceptive (birth control pills)-	□
Condoms	□	***Please specify pill name**_____	
Hormone Implant	□	Post-Menopausal	□
Hormone Shot (Depo or Other)	□	Tubal Ligation	□
Partner Vasectomy	□	Vaginal Ring (NuvaRing)	□
Hysterectomy	□	**NO CONTRACEPTION**	□
N/A **Male**	□	Other- **Please Specify** _____	□

What is your reason for being seen today?_____

Patient Signature (or authorized representative): _____

Date ___/___/___

Pharmacy Name: _____ Phone: _____