SODERSTROM SKIN INSTITUTE, PEORIA AMBULATORY SURGERY CENTER & HARLAN DERMATOLOGY MEDICAL HISTORY FOR DERMATOLOGY

(please print)

Patient Name: _____ Date of Birth: _____

Reason(s) for visit (chief complaint) _____ Height: _____ Weight: _____

Name of Primary Care Physician _____

Allergies (Check all that apply):

☐ No Known Allergies	☐ Aspirin	☐ Eggs	☐ Milk/Dairy
☐ Latex	☐ Bee Stings	☐ Peanuts	☐ Adhesive Tape
☐ Lidocaine	☐ Vaccines	☐ Shellfish	

Other: _____

List all current prescribed medications – if none please indicate none

Prescribed / Vitamins / Supplements / Dose / Frequency

_____ _____

_____ _____

_____ _____

_____ _____

PAST MEDICAL HISTORY

Have you ever had any of the following conditions?

Please check yes or no to all:

Depression	❑ Y	❑ N	Cardiac Issues	❑ Y	❑ N	HIV Infection/AIDS	❑ Y	❑ N
Basal Cell Carcinoma	❑ Y	❑ N	Dementia	❑ Y	❑ N	Hepatitis B or C	❑ Y	❑ N
Squamous Cell Carcinoma	❑ Y	❑ N	Pacemaker	❑ Y	❑ N	MRSA, C-diff or VRSA Infection	❑ Y	❑ N
Malignant Melanoma	❑ Y	❑ N	Defibrillator	❑ Y	❑ N	Other Infectious Diseases	❑ Y	❑ N
Psoriasis	❑ Y	❑ N	Organ Transplant	❑ Y	❑ N	Confirmed COVID-19 Diagnosis	❑ Y	❑ N
Eczema	❑ Y	❑ N	Asthma	❑ Y	❑ N	Have you been out of the country		
Cold Sores	❑ Y	❑ N	Tuberculosis	❑ Y	❑ N	(USA) in the past 30 days?	❑ Y	❑ N
Hives	❑ Y	❑ N	Liver Disease	❑ Y	❑ N	Cancer	❑ Y	❑ N
Use of Tanning Beds	❑ Y	❑ N	Kidney or Bladder Disease	❑ Y	❑ N	Other (list):	❑ Y	❑ N
Lupus	❑ Y	❑ N	Currently on Dialysis	❑ Y	❑ N			
Diabetes	❑ Y	❑ N	Joint Replacement	❑ Y	❑ N			
Thyroid Disease	❑ Y	❑ N	Dental Implants	❑ Y	❑ N			
Anemia	❑ Y	❑ N	Any other Implants	❑ Y	❑ N			

If you checked any of the boxes above, please list any additional details here.

_____

_____

_____

Please Continue on Other Side

Females
Pregnant ❑ Y ❑ N ❑ NA # of weeks _____

Planning to become pregnant ❑ Y ❑ N ❑ NA
Hysterectomy ❑ Y ❑ N ❑ NA
Breast Feeding/Nursing ❑ Y ❑ N ❑ NA
History of irregular periods ❑ Y ❑ N ❑ NA

Patient Surgical History

List all past surgeries and hospitalization(s) for the last 10 years – if none please indicate none

Surgery/Hospitalization/year _____ _____

_____ _____

_____ _____

Vaccination Status (Check all that apply and include date received, if known):

❑ Pneumococcal (pneumonia) _____ ❑ Covid-19 _____
❑ Flu _____ ❑ Shingles _____

Patient's Family History - check the following medical conditions that occurred in the patient's family and indicate which relative (mother, father, grandparent, sibling or other blood relative):

	Relative		Relative
☐ No Family History		☐ Heart Disease	
☐ Allergies/Hayfever/Asthma		☐ High Blood Pressure	
☐ Anesthesia Problems		☐ Malignant Hyperthermia	
☐ Autoimmune Disorders		☐ Arthritis	
☐ Breast Cancer		☐ Lung Disease	
☐ Other Cancer		☐ Tuberculosis	
☐ Skin Cancer		☐ G6PD deficiency	
☐ Malignant Melanoma		☐ Stroke	
☐ Skin Disease		☐ Blood Clotting Disorders	
☐ Diabetes		☐ Muscular Dystrophy	
☐ Psoriasis		☐ Other	
☐ Eczema			

Patient Social History

Alcohol Consumption: ☐ No Use of Alcohol Use ☐ Socially ☐ Daily ☐ History of Alcoholism
Recreational Drugs: ☐ No Use of Drugs ☐ Current Use of Drugs ☐ History of Drug Use
Use of Marijuana: ☐ No Use of Marijuana ☐ Medical Use ☐ Social Use

Smoking Status: ☐ Never ☐ Former Smoker: # of years _____ # of packs/day_____
☐ Current Smoker: # of years _____ # of packs/day_____

I certify all the information provided above is accurate and complete to the best of my knowledge.

Patient, Guardian or POA Signature X_____ History Date: _____