OHIO SKIN CENTER
DERMATOLOGY · SURGERY · COSMETICS

PATIENT MEDICAL HISTORY

CONDITIONS & MEDICATIONS

LIST ANY MEDICAL HEALTH CONDITIONS (INCLUDING THOSE FOR WHICH YOU ARE NOT TAKING MEDICATION)
CHECK IF YOU ARE ON NO MEDICATIONS: _____ CHECK IF PROVIDING A COPY TO THE STAFF: _____

CONDITION	MEDICATION

ARE YOU CURRENTLY **PREGNANT**? _____ YES _____ NO ARE YOU CURRENTLY **BREASTFEEDING**? _____ YES _____ NO
DO YOU HAVE ANY **DRUG ALLERGIES**? _____ YES _____ NO
IF YES, PLEASE SPECIFY TYPE AND REACTION: _____

HOSPITALIZATIONS & PROCEDURES

LIST ALL SIGNIFICANT HOSPITALIZATION(S) AND/OR SURGICAL PROCEDURE(S)

DESCRIPTION	MONTH/YEAR

MEDICAL

DO YOU HAVE, OR EVER HAD:	YES	NO			YES	NO
ABNORMAL HEALING				HIV AND/OR AIDS		
ABNORMAL BLEEDING OR BRUISING				IMPETIGO (SKIN INFECTION)		
ALLERGIES OR ASTHMA				IRREGULAR HEARTBEAT OR PACEMAKER		
BLOOD CLOTS				JAUNDICE, HEPATITIS, OTHER LIVER DISEASE		
BLOOD DISEASES OR ANEMIA				KELOID OR EXCESSIVE SCARRING		
CANCER (OTHER THAN SKIN)				KIDNEY DISEASE		
COLD SORES OR GENITAL HERPES				LUNG DISEASE OR SHORTNESS OF BREATH		
DIABETES				MELANOMA		
ECZEMA				MELASMA (MASK OF PREGNANCY)		
HAY FEVER				PROBLEMS WITH SKIN PIGMENTATION		
HEART TROUBLE OR HEART MURMUR				PSYCHOLOGICAL OR PSYCHIATRIC ISSUES		
HIGH OR LOW BLOOD PRESSURE				SKIN CANCER		
DO YOU, OR HAVE YOU:	**YES**	**NO**		**FAMILY HISTORY OF:**	**YES**	**NO**
DRINK ALCOHOL				ECZEMA		
SMOKE/CHEW TOBACCO				PSORIASIS		
GO TO TANNING SALONS				HAY FEVER, ALLERGIES OR ASTHMA		
WORK OUTDOORS				MELANOMA		
HAD X-RAY TREATMENT TO YOUR SKIN				SKIN CANCER (NO MELANOMA)		
HAD SEVERE OR BLISTERING SUNBURN(S)						
HAD A REACTION TO LOCAL ANESTHESIA						

SKIN PROBLEMS

WHAT IS/ARE YOUR SKIN PROBLEM(S)? WHEN DID IT START? WHAT HAVE YOU TREATED IT WITH? WHAT CONCERNS YOU MOST?

_____

SIGNATURE: **DATE:**