Valley Medical Group
Valley Health System

Today's Date: _____

PATIENT VISIT/MEDICAL HISTORY - Dermatology

Patient Name: _____ Date of Birth: _____

Address: _____

_____

Phone: _____ (☐ Home ☐ Cell ☐ Work) E-Mail: _____

Primary Insurance Company: _____ Policy #:_____

Primary Insurance Policy Holder Name: _____ ☐ Self ☐ Spouse ☐ Other

Secondary Insurance Company: _____ Policy #:_____

Secondary Insurance Policy Holder Name: _____ ☐ Self ☐ Spouse ☐ Other

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

CHIEF COMPLAINT TODAY (Please check the reason for your visit today)

☐ Acne	☐ Mole (Changing)	☐ Skin rash/problem
☐ Alopecia/Hair Loss	☐ Molluscum Contagiosum	☐ Total body skin exam/skin cancer screening
☐ Eczema/Atopic dermatitis	☐ Pruritus/itching	
☐ History of skin cancer	☐ Psoriasis/Seborrheic dermatitis	☐ Wart(s)
☐ Hives	☐ Ringworm	☐ Other:
☐ Impetigo/Skin infection	☐ Rosacea	☐ Other:
☐ Insect Bite(s)	☐ Scar/Keloid Scar	☐ Other:

ALLERGIES/ADVERSE REACTIONS

Medications	**Reaction**	**Food/Other** (please list)	**Reaction**
☐ Doxycycline		☐ Latex	
☐ Erythromycin		☐ Other:	
☐ Minocycline		☐ Other:	
☐ Penicillin		☐ Other:	
☐ Sulfa		☐ Other:	
☐ Tetracycline		☐ Other:	

Patient Name: _____ Date of Birth: _____

CURRENT MEDICATIONS (Please list all Prescription Drugs, Over-the-Counter Medications, Herbs and Vitamins that you are currently taking). Please include topical medications.

Name of Medication/Herb/Vitamin	**Dosage** (mg/ml)	**Frequency**

PAST MEDICAL HISTORY (Please check those items that apply)

☐ Abnormal Healing	☐ Diabetes	☐ Pacemaker
☐ Accutane/Isotretinion Treatment	☐ Emphysema	☐ Radiation Treatment
☐ AIDS	☐ Fainting/Passing out	☐ Rhematologic Disease
☐ Artificial Joints	☐ Gastrointestinal Disease	☐ Rheumatoid Arthritis
☐ Asthma	☐ Heart Attack	☐ Seizures/Epilepsy
☐ Bladder Disease	☐ Heart Murmur	☐ Shortness of breath/SOB
☐ Bleed Easily	☐ Hepatitis	☐ Skin Cancer
☐ Blood Clot	☐ Herpes/Cold Sores	☐ Skin Conditions
☐ Bronchitis	☐ High Blood Pressure	☐ Thyroid Disease
☐ Cancer	☐ High Cholesterol	☐ Wheezing
☐ Chest Pain	☐ HIV	☐ Other:
☐ Chronic Cough	☐ Irregular Heartbeat	☐ Other:
☐ Congenital Heart Disease	☐ Keloid Scars	☐ Other:
☐ Defibrillator	☐ Kidney Disease	☐ Other:

SURGICAL HISTORY (Please check previous surgeries that you have had, including date)

Procedure	**Date of Surgery**	**Procedure**	**Date of Surgery**
☐ Botox/Neurotoxin		☐ Photodynamic Therapy	
☐ Cryosurgery		☐ Skin Surgery	
☐ Dermal Fillers		☐ Tumescent Liposuction	
☐ Hair Removal		☐ Vitiligo Surgery	
☐ Hair Transplantation		☐ Other Surgery:	
☐ Laser Therapy		☐ Other Surgery:	
☐ Mohs Surgery		☐ Other Surgery:	

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY (Please indicate the family member, onset age, age of death -if applicable)

Condition	Relation (Mother, Father, Sister, Brother, Son, Daughter, Maternal Grandmother/Grandfather/Aunt/Uncle, Paternal Grandmother/Grandfather/Aunt/Uncle)	Age when Diagnosed	Age of Death
☐ Skin Cancer			
☐ Skin Cancer			
☐ Skin Cancer			
☐ Skin Cancer			
☐ Other:			
☐ Other:			
☐ Other:			
☐ Other:			

SOCIAL HISTORY

Occupation: _____

Education: ☐ less than High School ☐ Some H.S. ☐ H.S. graduate or equivalent ☐ 2 Year College ☐ 4 Year College ☐ Post Graduate

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy How many drinks per week?_____

Smoking Status: ☐ Never ☐ Former ☐ Current Every Day ☐ Current Some Day ☐ Current Status Unknown

Smoking – How much? ☐ None _____Pack(s) Per Day _____Pack(s) Per Week Has smoked since age _____

Illicit Drugs: _____

Sunscreen used routinely: ☐ Yes ☐ No Blistering Sunburns: ☐ Yes ☐ No

Do you or did you ever visit tanning salons? ☐ Yes ☐ No

Women Only: Pregnant/Trying to become pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No

GYN HISTORY (*Women Only)*

Duration of Flow _____(days) Frequency of Cycle _____(Q days)

Regular Menstrual Periods? ☐ Yes ☐ No