

# NORTH IDAHO DERMATOLOGY

## Medical History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

Referred By: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

**CURRENT OR PAST PROBLEMS WITH: (if yes, please explain)**

	Yes	No		Yes	No
General Health	<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Bowels	<input type="checkbox"/>	<input type="checkbox"/>
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Muscles/Joint	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Blood/Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/TB/HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Skin (other than above)	<input type="checkbox"/>	<input type="checkbox"/>			

Check the following medical conditions that have occurred in your family:

	Mother	Father	Blood Relative
Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you live alone? \_\_\_\_\_no \_\_\_\_\_yes

Do you drink alcohol? \_\_\_\_\_no \_\_\_\_\_yes - frequency \_\_\_\_\_

Do you smoke? \_\_\_\_\_no \_\_\_\_\_yes - frequency \_\_\_\_\_

Alcohol/drug problems/addictions? \_\_\_\_\_no \_\_\_\_\_yes - describe \_\_\_\_\_

Occupation \_\_\_\_\_

Sunlight exposure \_\_\_\_\_mild \_\_\_\_\_moderate \_\_\_\_\_extensive

Female: Are you pregnant? \_\_\_\_\_no \_\_\_\_\_yes

**THIS SECTION ONLY TO BE COMPLETED BY PATIENT**

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**THE BELOW INFORMATION TO BE COMPLETED BY PHYSICIAN**

CC	
Location	
Severity	
Duration	
Change	itching / painful / stinging / no symptoms
Modifying Factors	
Prev Tx	
Prev Bx	

Hx of Psoriasis y/n                      Hx of Eczema y/n                      Hx of Skin Cancer y/n                      Hx of Asthma y/n

Do you bleed easily \_\_\_\_\_yes \_\_\_\_\_no. Do you have problems with healing or scarring \_\_\_\_\_yes \_\_\_\_\_no.

Medical history reviewed by \_\_\_\_\_ to medicine or food \_\_\_\_\_yes \_\_\_\_\_no.

*Physical Exam*

**THE BELOW INFORMATION TO BE COMPLETED BY PHYSICIAN**

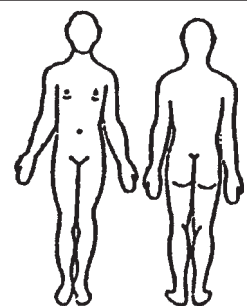
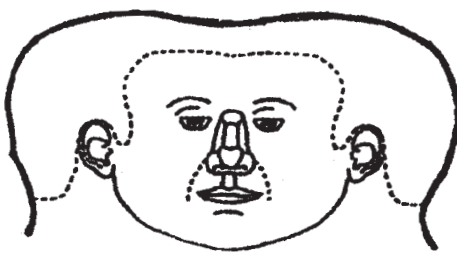
Name \_\_\_\_\_ Date \_\_\_\_\_

General Appearance \_\_\_\_\_

**SKIN-BODY AREAS**

	Normal	Abnormalities
Eyes/Conj/Lids	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Ears	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Lips/Teeth/Gums	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Lymph Nodes	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Scalp	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Face	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Neck	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Chest/Axilla	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Abdomen	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Back	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Groin/Buttocks	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Right Upper ext.	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Left Upper ext.	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Right Lower ext.	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Left Lower ext.	<input type="checkbox"/> Normal	<input type="checkbox"/> _____
Digits/Nail	<input type="checkbox"/> Normal	<input type="checkbox"/> _____

X - actinic keratosis       - biopsy site  
 ⊗ - serborrheic keratosis      ● - nevus



**ASSESSMENT / PLAN**

\_\_\_\_\_

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**DICTATION:** \_\_\_\_\_

**RTC:** \_\_\_\_\_