



HORWITZ DERMATOLOGY
MEDICAL • COSMETIC • SURGICAL

Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Referring Doctor: _____ Family Physician: _____

Reason for today's visit: _____

Are you allergic to any medications: Yes No What kind of allergic reaction: _____

Local Anesthetics _____ Aspirin _____ Penicillin _____ Sulfa _____

Codeine _____ Erythromycin _____ Tetracycline _____

Others, please list _____

List all medications you are currently taking: (if needed, list additional medications on back):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

General:

Do you have now, or have you ever had, any of the diseases or conditions following:

(Please check Yes or No)

	Yes	No		Yes	No
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Chronic/Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/AICD	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma/Eye Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis or Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>

HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>			

Please answer the following questions:

Do you smoke? Yes No If YES, how much: _____ per day.
 Do you drink alcohol? Yes No If YES, _____ per day.
 (Women only) Are you pregnant? Due Date: _____ Yes No
 Do you have artificial joint(s)? Yes No
 Do you require antibiotics prior to surgery? Yes No
 Have you ever had dental anesthesia (Lidocaine or Novacaine) Yes No
 Any bad reaction: Yes No
 List any other disease or condition we should know about: _____
 List surgical procedures you have had : _____

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Dermatologic History

Has anyone in your family ever had: Family Member:

Melanoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Non-melanoma skin cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Precancerous Keratoses	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Unusual Moles	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Allergic Skin Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ (Hives, Eczema, Dermatitis, Drug Rash)	
Respiratory Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ (Asthma, Hay Fever, Sinus Problems)	
Severe Acne	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Sunlight Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Autoimmune Diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ (Lupus, Scleroderma, Raynaud's, Dermatomyositis)	

Have **you** ever had:

Melanoma Yes No

Non-melanoma skin cancer Yes No

Precancerous Keratoses Yes No

Unusual Moles Yes No

Psoriasis Yes No

Allergic Skin Conditions Yes No

(Hives, Eczema, Dermatitis, Drug Rash)
Respiratory Allergies Yes No

(Asthma, Hay Fever, Sinus Problems)
Acne Yes No

Sunlight Sensitivity Yes No

Autoimmune Diseases Yes No

(Lupus, Scleroderma, Raynaud's, Dermatomyositis)
Cold Sores Yes No

(Fever Blisters, Herpes Labialis)

How would you best describe your reaction to sun exposure:

- Always burn, never tan
- Often burn, sometimes tan
- Rarely burn, always tan
- Never burn, tan darkly