

**Dorset Street Dermatology, LLC**  
**Medical History Form**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Are you allergic to any medications?**  Yes  No If yes, please list below: \_\_\_\_\_

Have you ever had dental anesthesia (Novocaine)?  Yes  No Did you have a bad reaction?  Yes  No

**List all medications, vitamins, and supplements you are currently taking:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have or have you ever had the following diseases or conditions (please leave blank if unknown):

**Lungs:**

Bronchitis  Yes  No  
Emphysema  Yes  No  
Asthma  Yes  No  
Chronic Cough  Yes  No  
Morning Cough  Yes  No  
Wheezing  Yes  No

**Cardiovascular:**

High Blood Pressure  Yes  No  
Chest Pain  Yes  No  
Heart Attack  Yes  No  
Heart Murmur  Yes  No  
Irregular Heartbeat  Yes  No  
Phlebitis  Yes  No  
Pacemaker  Yes  No

**Other Systemic:**

Diabetes  Yes  No  
Thyroid  Yes  No  
Kidney  Yes  No  
Bladder  Yes  No  
Gastrointestinal  Yes  No  
Stomach upset when taking antibiotics  Yes  No  
Yeast infection when taking antibiotics  Yes  No  
Arthritis/Joint Deformity  Yes  No  
Arthralgia  Yes  No  
Limited motion  Yes  No  
Artificial Joint  Yes  No  
Convulsions, seizures, epilepsy  Yes  No  
Fainting  Yes  No

List any other diseases or conditions: \_\_\_\_\_

List surgical procedures you have had in the last 6 months: \_\_\_\_\_

**Skin:**

Have you ever had skin cancer?  Yes  No If YES, type: \_\_\_\_\_  
Has anyone in your family had skin cancer?  Yes  No If YES, type: \_\_\_\_\_  
Do you have a history of any specific skin diseases?  Yes  No If YES, type: \_\_\_\_\_  
Do you have problems with healing?  Yes  No  
Do you develop keloids (scars) after surgery?  Yes  No  
Do you bleed easily?  Yes  No  
Do you develop skin rashes in reaction to:  Medications  Food  Environment  Bandages  Neosporin  
 Other \_\_\_\_\_

**Other History:**

Do you use tobacco?  Yes  No If YES, what and how often? \_\_\_\_\_  
Have you been diagnosed with or have you been exposed to HIV (AIDS)?  Yes  No  
Have you been diagnosed with or do you currently have a MRSA infection?  Yes  No

Name and location of your pharmacy: \_\_\_\_\_

(Women) Are you pregnant or breastfeeding?  Yes  No Due Date: \_\_\_\_\_

What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_