

Aloha Dermatology - Patient Medical History

Name _____ DOB _____ Age: _____

Skin complaint: _____

Where? _____ When did it start? _____

Symptoms: pain itching bleeding other -> _____

What medications have you tried? _____

<u>List all your current Medications</u>	<input type="checkbox"/> NONE
_____	_____
_____	_____

Allergies to medication: (List with reaction you had) _____

MEDICAL HISTORY None, I'm basically healthy

Skin Problems

Psoriasis Eczema/Dermatitis Acne Other Skin Problem: _____

Skin Cancer: (Where and What type) _____

Anyone in your family have skin cancer? (If yes, who?) _____

Lung Problems

Bronchitis Emphysema Asthma Chronic Cough

Vascular Problems

High Blood Pressure Chest Pain Heart Attack Irregular Heartbeat
 Pacemaker Blood Clots/Phlebitis Bleeding Problem Blood thinners

Other Medical Problems

Diabetes Thyroid (high or low) Kidney Bladder Stomach Stroke
 Bowel Hepatitis B or C Glaucoma Arthritis/Joint HIV

Cancer (type) _____

Past surgeries: _____

Diseases that run in your family? (If yes, please list) _____

Other medical problems? _____

Please answer the following questions

Do you take antibiotics for dental procedures? Y N If yes, why? _____

Do you smoke? Y N

Have you had problems with local anesthesia? Y N

Are you allergic to latex products? Y N Please let staff know if you are latex allergic

Is there anything else we should be aware of? Y N _____

Women Only

Are you pregnant? Y N **If you answered yes to these questions,**

Are you trying to become pregnant? Y N **please let Dr. Wong or the staff know.**

Are you breast feeding? Y N

Patient Signature (or Guardian): _____ DATE _____