Koger Dermatology Patient Medical History

Name	Age	DOB
Main Reason for today's visit:		
Where is it located?	How long has it been present?	
Severity – how bad is it?		
Have you ever had a similar problem in the past and when?		
What other signs and symptoms are you experiencing?		
☐ Bleeding ☐ Growing ☐ Sore ☐ Itching ☐ Burning ☐ Changing		
Have you used anything that makes it better / worse?		
Please list all prescriptions / over the counter medications and vitamins you take: None ☐		
Please list all Allergies None ☐		

Family History Please check if YES					
Skin Cancer	☐	Melanoma	☐	Psoriasis	☐
Lupus	☐	Rheumatoid Arthritis	☐	Eczema / Hay Fever / Asthma	☐
Diabetes	☐	Thyroid Problems	☐	Hair Loss/ Thinning / Baldness	☐

Ethnicity / Race	Occupation
Tobacco Use / Frequency	Lifetime Number of Peeling Sunburns
Tanning Bed Use / Frequency	Alcohol Use / Quantity
Females: Pregnant ○ Nursing ○ LMP:	Recent Surgery
Has anything changed with your health since your last visit?	

Do you have any of the following? Please check if YES			
Need antibiotics when having dental work	☐	Sinus or lung disease (asthma, emphysema/COPD)	☐
Recent fever, fatigue or weight loss	☐	High blood pressure	☐
Thick scarring from surgery	☐	Heart attack	☐
New, changing or abnormal moles	☐	Abnormal bleeding / Hemophilia	☐
Hair disorders	☐	Skin allergies	☐
Nail problems	☐	HIV / AIDS	☐
Muscle or joint pain	☐	Liver disease / Hepatitis	☐
Bleeding problems, bleed easily	☐	Specific skin disease (type)	☐
Stomach or intestinal problems with medications	☐	Rheumatologic disease, arthritis, lupus	☐
Fainting spells / seizures	☐	Diabetes, thyroid or other hormone disease	☐
Difficulty breathing / shortness of breath	☐	Stroke, severe headaches, nerve problems	☐
Slow or rapid heart rate	☐	Frequent infections	☐
Grittiness or burning of the eyes	☐	Skin cancer ☐ What type	
Drying peeling, itching, flaking or burning skin	☐	Photo-sensitivity, burn easily	
Cancer ☐ If yes, what type		Other	

I understand the information above is an important part of my medical care and I have answered all of the above questions truthfully and to the best of my abilities.

Patient or Guardian Sign Here X_____ Date_____

Initial History Interval History Review Date