There are 2 options.

1. You can simply print this out and complete in pen.
2. You can type in the shaded areas, or click on shaded areas near yes or no questions to create a ✓ mark.

Save the file before printing to avoid losing information. Please sign your name and enter the date in pen.

MGH Dermatology Service
Patient History Form (Adult Dermatology)

PRIMARY CARE PHYSICIAN:

Physician name :_____

Physician address:_____

City_____State_____ Zip_____

Telephone_____

Did a physician refer you to the Dermatology Service? __ no __ yes

Same as above

Name _____

Address_____

City_____ State_____Zip_____

Telephone_____

I authorize dermatology to leave messages on my (please check off):

Home phone: (____)_____

Day/Work phone: (____)_____

Cell phone: (____)

PRESENT PROBLEM(S): What is the purpose of your visit today?

_____

PAST HISTORY:

Do you have any medical problems? Please place a check ✓ mark and complete.

Diabetes ☐ Asthma ☐ Liver Disease ☐ Hayfever ☐ High Blood Pressure ☐

Cancer (specify type) _____ Other_____

Do you have a pacemaker? ____ no ____ yes
Do you have an artificial joint? ____ no ____ yes
Do you have an artificial heart valve? ____ no ____ yes
Do you have to take antibiotics before you go to the dentist? ____ no ____ yes (why?)_____
Have you used tanning beds? _____no ____ yes

MEDICATIONS: Do you take any prescription or over-the-counter medications regularly?
Please list
(1)_____(2)_____(3)_____

(4)_____(5)_____(6)_____

Are you allergic to any medications? ____ no _____ yes If yes (please list)

_____

Do you take blood thinners? ____ no _____ yes(please list)_____

Have you taken any aspirin in the last 48 hours? ____ no _____ yes

Please Complete Page 2

FAMILY HISTORY: Are there any diseases that run in your family? ____no ____yes (please list)

_____

Do you or any of your blood relatives have melanoma? __ no ___ yes (relationship)_____
Do you or any of your blood relatives have non-melanoma skin cancer? __ no ___ yes (relationship)_____
Do you or any of your blood relatives have psoriasis? __ no ___ yes (relationship) _____
Do you or any of your blood relatives have eczema? __ no ___ yes (relationship) _____

SOCIAL HISTORY: Do you smoke? ____ no ____ yes
Do you drink alcohol beverages on a regular basis? ____ no ____ yes

OCCUPATION: What kind of work do you do? _____

REVIEW OF SYSTEMS:
Do you have any current or past problems with any of the following? **Please describe**

General Health ____ no ____ yes _____
Eyes ____ no ____ yes _____
Ears/Nose/Throat/Mouth ____ no ____ yes _____
Heart ____ no ____ yes _____
Liver ____ no ____ yes _____
Lungs ____ no ____ yes _____
Stomach/Bowel ____ no ____ yes _____
Kidneys ____ no ____ yes _____
Headaches/Seizures ____ no ____ yes _____
Psychological disorder ____ no ____ yes _____
Thyroid/Diabetes ____ no ____ yes _____
Blood/Bleeding disorder ____ no ____ yes _____
Females: Are you pregnant? ____ no ____ yes _____
Planning to become pregnant? ____ no ____ yes _____

I authorize the Dermatology Service to release medical information to the referring physicians

_____ _____
Patients Signature Today's Date Physicians Signature Date

Revised: 4/19/10