Jacks Dermatology 1710 West 42nd Avenue | Pine Bluff, AR 71603 870-534-7546

DERMATOLOGY MEDICAL HISTORY

Name:	Age:	DOB:	Sex: **M F**	Race:
Reason for today's visit:				
Family Physician:		Referring Physician:		
Are you allergic to any medications? **Yes No**	*If yes, please list:*			

Please List all current medications (including prescriptions, over-the-counter, vitamins, and herbals): *Use back if necessary*

Medication	Dosage	Medication	Dosage	Medication	Dosage
1.		4.		7.	
2.		5.		8.	
3.		6.		9.	

Please check if you have or ever had the following diseases/ conditions:

Medical History	Yes	No	Explain	Skin History	Yes	No	Explain
Allergies				Acne			
Arthritis				Actinic Keratosis			
Asthma				Basal Cell Carcinoma			
Autoimmune Disorder				Dysplastic Nevus			
Bleeding Disorder				Eczema			
Breast Cancer				Fever Blister			
Cancer				Keloid Scars			
Depression				Malignant Melanoma			
Diabetes				Onychomycosis			
Dysplastic Nevus				Other			
Easy Bleeding				Suspicious Lesions			
Eczema				Psoriasis			
Gastrointestinal				Rash			
Heart Disease				Rosacea			
Heart Murmur				Seborrheic Dermatitis			
Hepatitis				Skin Cancer			
High Blood Pressure				Squamous Cell Carcinoma			
Hives				Urticaria			
Hyperlipidemia				Vitiligo			
Kidney Stones				Warts			
Neurological Disorder				**Social History**	**Yes**	**No**	**Explain**
Other				Do you smoke?			Packs per day/week:
Psychiatric Disorder				Do you drink alcohol?			Drinks per day/week:
Seizures				Have you ever been exposed to HIV/AIDS?			
Stroke							
Thyroid Disorder				**Has a family member had a skin cancer?**			*If yes, whom?*
Tuberculosis				**Do you tan? *Indoor or Outdoor***			*If yes, how often?*
Ulcers				**Completed By: *Please Check One***			
X-Ray Therapy				☐ Patient	☐ Parent		
Are You Pregnant?			**Due Date:**	☐ Guardian	☐ Medical Assistant		

Surgical History

Surgery:	Date:	Surgery:	Date:

Family Medical History

Disease/Condition	Relation	Disease/Condition	Relation

Patient/Parent/Guardian Signature:		**Date:**
Reviewed by Provider:		**Date:**