THE DERMATOLOGY CENTER OF INDIANA

Patient Dermatology History Form

Demographics:

Name: _____ ☐ Jr. ☐ Sr. Date: _____/_____/_____
First Middle Last Month Day Year

Primary Reason For Today's Visit (Please describe: I.e. how long with problem? What have you tried? Etc)

_____

_____

Allergic to any medications?: ☐Yes ☐ No If YES, Please list: (1) _____
(2) _____ (3) _____ (4) _____

Have you ever had local or dental anesthesia? ☐Yes ☐ No If YES, any bad reactions: ☐Yes ☐ No

Current Medications with dosages (Include Prescription, Over the counter, Vitamins, herbals) **LIST ON BACK if not enough room**

(1) _____ (2) _____ (3) _____

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

(7) _____ (8) _____ (9) _____ **? More on back** ☐ Yes

Do you have now or have you ever had diseases or conditions of **(Please check YES or NO)**?

Cardiovascular / Heart		**Pulmonary / Lungs**		**Other**	
High Blood Pressure	☐Yes ☐ No	Bronchitis	☐Yes ☐ No	Diabetes	☐Yes ☐ No
Chest Pain / Angina	☐Yes ☐ No	Emphysema	☐Yes ☐ No	Thyroid	☐Yes ☐ No
Heart Attack	☐Yes ☐ No	Asthma	☐Yes ☐ No	Kidney	☐Yes ☐ No
Heart Murmur	☐Yes ☐ No	Chronic Cough	☐Yes ☐ No	Bladder	☐Yes ☐ No
Irregular Heartbeat	☐Yes ☐ No	Wheezing	☐Yes ☐ No	Joints/Arthritis	☐Yes ☐ No
Blood Clots	☐Yes ☐ No			Fainting	☐Yes ☐ No
Stomach / GI		**Neurological / Brain**		Artificial Joint	☐Yes ☐ No
Ulcers / GERD	☐Yes ☐ No	Stroke / TIAs	☐Yes ☐ No	HIV / AIDS	☐Yes ☐ No
Hepatitis	☐Yes ☐ No	Seizures	☐Yes ☐ No	Cancer	☐Yes ☐ No
If yes hepatitis TYPE: _____		Numbness / Tingling	☐Yes ☐ No	If yes Cancer, List Type:	

Pacemaker ☐Yes ☐ No **Do you smoke**? ☐Yes ☐ No _____
Artificial Heart Valve ☐Yes ☐ No **Any Alcohol Use**? ☐Yes ☐ No
Other Medical Conditions or surgeries not already noted? _____

_____

Any PERSONAL history of skin cancer? ☐Yes ☐ No If yes, Type and Date (if known) _____

_____

Any FAMILY history of skin cancer? ☐Yes ☐ No If yes, Type (If Known) _____
Any PERSONAL history of other skin disease? ☐Yes ☐ No If yes, What? _____
Any FAMILY history of other skin disease? ☐Yes ☐ No If yes, What _____
Any PERSONAL history of KELOIDS after surgery ? ☐Yes ☐ No
WOMEN ONLY : Are you pregnant? ☐Yes ☐ No If yes, Due Date: _____
Occupation : _____ **Hobbies :** _____
Completed By: ☐ Patient ☐ Parent / Guardian, Signature (Patient or Other) _____

Nurse / MA : _____ Date: _____
Scott T. Guenthner, MD.: _____ Date: _____
Michaela Wehr,PA-Cc: _____ Date: _____
Jennifer White, NP-BC_____ Date:_____
Jeremy Nivens, NP-BC_____ Date:_____
Dennae Noblitt, PA-C _____ Date:_____

Reviewed: (1)_____ _____ (2)_____ _____ (3)_____ _____ (4)_____ _____
INITIALS DATE INITIALS DATE INITIALS DATE INITIALS DATE