Melissa Morgan, M.D., P.C.
Dermatology Medical History

Patient: _____ Date of Birth: _____ Today's Date: _____

Reason for today's visit: _____

Are you allergic to any medications? ☐**YES** ☐ **NO** If yes, please list: _____

_____

List all medications you are currently taking (including prescriptions, over-the-counter medicines, vitamins, and herbals):

1._____ 3._____ 5._____

2._____ 4._____ 6._____

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

Lungs	**YES**	**NO**
Emphysema	_____	_____
Asthma	_____	_____
Tuberculosis	_____	_____
Blood Clots	_____	_____
(Pulmonary Embolus)	_____	_____
Cardiovascular	_____	_____
High Blood Pressure	_____	_____
Chest Pain	_____	_____
Heart Attack	_____	_____
Heart Murmur	_____	_____
Irregular Heartbeat	_____	_____
Phlebitis	_____	_____
Inflammation of veins	_____	_____
Blood Clots	_____	_____
Pacemaker	_____	_____
Automatic Internal Defibrillator	_____	_____
Cancer	_____	_____
Type_____		

Other Systemic	**YES**	**NO**	
Diabetes	_____	_____	
Lupus	_____	_____	
Thyroid	_____	_____	
Kidney	_____	_____	
Dialysis	_____	_____	
Depression	_____	_____	
Gastrointestinal	_____	_____	
Hepatitis	_____	_____	
Stomach Ulcers	_____	_____	
Yeast infection when taking antibiotics	_____	_____	
Arthritis Type _____	_____	_____	
Fever blisters on lips	_____	_____	
Joint Replacement	_____	_____	Type_____ Year
Convulsions, Epilepsy	_____	_____	
Seizures	_____	_____	
Fainting	_____	_____	
Glaucoma	_____	_____	
Hives	_____	_____	

List any surgical procedures you have had in the last 6 months

_____

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Have you ever had skin cancer? ☐**YES** ☐ **NO**

Has anyone in your family had skin cancer? ☐**YES** ☐ **NO**

Do you have a history of any specific skin diseases? ☐**YES** ☐ **NO** If yes, _____

Do you have problems with healing? ☐**YES** ☐ **NO**

Do you develop keloids (scars) after surgery? ☐**YES** ☐ **NO**

Do you bleed easily? ☐**YES** ☐ **NO**

Do you develop skin rashes in reaction to:

☐Medications ☐Food ☐Environment ☐Bandages ☐ Topical Neosporin

☐Other_____

Social History:

Do you drink alcohol? ☐ **YES** ☐**NO** If YES, _____drinks per day

Do you use IV drugs? ☐ **YES** ☐**NO** If YES, what?_____ How often?_____

Do you smoke? ☐ **YES** ☐**NO** If YES, how much:_____

Have you had or have you been exposed to HIV (AIDS)? ☐ **YES** ☐ **NO**

Please answer the following questions:

(Women) Are you pregnant? ☐ **YES** ☐ **NO** Due Date: ___/___/_____

Are you nursing? ☐ **YES** ☐ **NO**

What is your occupation? _____Hobbies?_____

_____ ___/___/_____

Signature of Patient Date