Dermatology Specialists
Oyster Point Dermatology, Inc.

Patient Medical History

Date _____

Patient's Name _____ Date of Birth _____ Age _____

Referring Physician _____ Primary Care Physician _____

Reason for today's visit _____

Please Check All That Apply and Provide Details and Dates

❑ No Pertinent Past Medical History

Allergies

_____
_____
_____

Immunizations

❑ Shingles vaccine
❑ Pneumonia vaccine
❑ Flu vaccine
❑ Other Immunizations_____
Details: _____

Neurologic

❑ Neuropathy
❑ Deep brain stimulator (date/contact info)
❑ Stroke/TIA (date)
❑ Dementia/Alzheimer's
❑ Hearing impaired
❑ Other Neurologic _____
Details: _____

Heart - Cardiac

❑ Heart disease (date)
❑ Prior heart attack (date)
❑ Congestive heart failure (date)
❑ Valve replacement (date)
❑ Abnormal valve/Heart murmur
❑ Irregular heart beat (circle: A fib, PSVT, other)
❑ High blood pressure
❑ High cholesterol
❑ Other Cardiac _____
Details: _____

Endocrine

❑ Thyroid disorder: (circle: hypo or hyper)
❑ Diabetes
❑ Other Endocrine _____
Details: _____

Lungs - Pulmonary

❑ Asthma
❑ COPD (Emphysema)
❑ Sarcoidosis
❑ Other Pulmonary_____
Details: _____

GI - Gastrointestional

❑ Peptic ulcers
❑ Hepatitis (circle type: A, B, C)
❑ Liver disease
❑ Inflammatory bowel disease (circle type: Crohns, UC)
❑ GERD (Reflux)
❑ Other GI _____
Details: _____

Psychological

❑ Depression
❑ Anxiety
❑ Other Psychological _____
Details: _____

Urinary System

❑ Kidney disease
❑ Enlarged prostate
❑ Other Urinary _____
Details: _____

Muscles/Rheumatologic

❑ Arthritis (circle type: Osteo, Psoriatic, Rheumatoid, unknown)
❑ Autoimmune disease (circle: Lupus, Sjogren's Rheumatoid Arthritis)
❑ Raynaud's
❑ Other Rheumatologic _____
Details: _____

Immune System

❑ Seasonal allergies
❑ Transplant (circle: kidney, heart, liver)
❑ HIV/AIDS
❑ Blood problems (circle: anemia, bleeding disorder)
❑ Other Immunologic _____
Details: _____

Infectious Diseases

❑ Cold sores (Herpes)
❑ Tuberculosis and/or positive PPD
❑ Other Infectious _____
Details: _____

❑ No Pertinent Past Medical History

Cancer: Include diagnosis, treatment & year

❑ Breast
❑ Colon
❑ Leukemia, Lymphoma (type)
❑ Lung
❑ Other _____
Details: _____

Gynecologic - GYN

❑ Irregular menses
❑ Currently pregnant
❑ Currently breast feeding
❑ Planning future pregnancy
❑ Other GYN _____
Details: _____

Vascular Disease

❑ Blood clots (circle: legs, other _____)
Details: _____

Skin

❑ No significant skin history
❑ Acne or Rosacea
❑ Atypical moles
❑ Eczema
❑ Psoriasis
❑ Keloids or Hypertropic (thick) scars
❑ Sensitive skin
❑ Tanning bed use (how often?)
❑ Other Skin _____
Details: _____
_____
_____
_____

Skin Cancers: Include treatment & year

❑ Basal cell carcinoma
❑ Squamous cell carcinoma
❑ Malignant melanoma
❑ Other Skin Cancer _____
Details: _____
_____
_____
_____
_____
_____

Prior Treatments for Pre-Cancers of the Skin

(circle: Solaraze, Aldara, Zyclara, Carac, Flouroplex, Efudex, Picato, PDT, Chemical Peels, Laser Resurfacing)

❑ Other Treatments _____
Details: _____
_____
_____
_____
_____

Surgeries: Include year

❑ Cardiac (Heart)
❑ Joint replacement (circle: knee, hip, other/year)
❑ Tonsillectomy
❑ Gallbladder
❑ Vein stripping
❑ Tubal ligation
❑ Hysterectomy
❑ Cataract
❑ Cosmetic
❑ Other Surgeries _____
Details: _____

Pacemaker/Defibrillator

❑ Not applicable
❑ Pacemaker (copy card)
❑ Defibrillator (copy card)
❑ Pacemaker/Defibrillator combo
❑ Cardiologist and date
Details: _____

Family History (Skin cancers or skin conditions)

❑ Family history unknown - Adopted
❑ No family history of skin conditions
❑ Atypical moles
❑ Malignant Melanoma (Skin cancer)
❑ Skin cancers (SCC, BCC)
❑ Severe acne
❑ Autoimmune disorders
❑ Psoriasis
❑ Eczema
❑ **Other Pertinent Family History** _____
Details: _____

Social History

Do you use alcohol? ❑ Yes ❑ No
If Yes: ❑ Socially ❑ Intermittent ❑ Daily
Do you use illegal drugs? ❑ Yes ❑ No
If Yes, please explain: _____
Tobacco use: ❑ Never ❑ Former smoker
❑ Current usage: number of packs/day? _____
Occupation _____
Do you live alone? ❑ Yes ❑ No
Hobbies _____

Medications: Name of drug, dosage and frequency

Including Vitamins, Over-the-Counter Drugs, Herbal Remedies

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Do you take any blood thinners? ❑ Yes ❑ No
(Circle) Vitamin E, Plavix, Coumadin, Other _____
Do you take any NSAIDS? ❑ Yes ❑ No
(Circle) ibuprofen, naprosyn, aspirin, other _____
Do you need to take antibiotics prior to dental work? ❑ Yes ❑ No