Kennebec Medical Consultants

13 Railroad Square Suite 2
Waterville, ME 04901

PATIENT MEDICAL HISTORY
DERMATOLOGY

Please Print:

Current Medications Strength/Dosage Reason for taking

_____

_____

_____

_____

_____

Any Known Drug Allergies? _____

Please list any Previous Surgeries/Hospitalizations along with date performed: _____

_____

_____

DO YOU HAVE ANY SIGNIFICANT ILLNESSES WE SHOULD KNOW ABOUT?
□ Yes □ No Please explain: _____

Do you take blood thinners (I.E. Coumadin, Aspirin, etc)? □ Yes □ No
Do you have a Pacemaker? □ Yes □ No
Do you require antibiotics when you have dental work done? □ Yes □ No
Women: Are you pregnant, trying to become pregnant, or nursing? □ Yes □ No
If you are pregnant, when are you due? _____
Are you on a special diet? □ Yes □ No
If yes, what kind? _____

Do you use any of the following? (please circle all that apply):
Eyeglasses Dentures Contact Lenses Hearing Aid Artificial Limbs

Alcohol Use: □ Never □ Occasionally □ Daily Amount? _____/day
Tobacco Use: □ Never □ Yes □ Previously, but quit (Date) _____
Substance Abuse: □ Never □ Yes, Type/Frequency _____

Height: _____ Weight: _____ Race/Ethnicity/Ancestry: _____

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DERMATOLOGY

Please fill out following questions as completely as possible:

1) What is the purpose for todays visit? _____

2) Are you experiencing pain? □ Yes □ No If yes, how severe? (Circle one) Mild Moderate Severe

3) What other signs/symptoms are you experiencing? Bleeding Itching Burning Change of color/size
other: _____

4) How long have you been experiencing this condition? _____

5) Have you had a similar problem in the past? □ Yes □ No If yes, when? _____

6) What prescription and over the counter medications have you used that make it better/worse? _____

7) Family History: What conditions have your immediately family members had? (Check all that apply):

□ Skin cancer (other than melanoma) □ eczema/psoriasis □ baldness/hair loss/thinning hair
□ Abnormal moles/large number of moles □ melanoma □ lupus/rheumatoid arthritis
□ Diabetes or thyroid problems □ asthma □ hay fever/environmental allergies

8) Do you/have you ever used a tanning bed? □ Yes □ No If yes, how often? _____

9) Do you burn easily? □ Yes □ No If yes, lifetime # of peeling sunburns _____

10) Do you have any of the following?:

Depression/Anxiety/BiPolar	□ Yes □ No	Urinary Frequency/Urgency	□ Yes □ No
Recent fever, fatigue or weight loss:	□ Yes □ No	lung disease(asthma, emphysema, COPD):	□ Yes □ No
Thick scarring from surgery	□ Yes □ No	High Blood Pressure	□ Yes □ No
New, Changing or abnormal moles	□ Yes □ No	Heart Attack: if yes, when _____	□ Yes □ No
Hair Disorders/Nail problems	□ Yes □ No	Abnormal bleeding/Hemophilia	□ Yes □ No
Abdominal Pain/IBS	□ Yes □ No	Skin Allergies	□ Yes □ No
Fainting spells or seizures	□ Yes □ No	HIV/AIDS (CD4 count____, viral load___)	□ Yes □ No
Difficulty breathing/shortness of breath	□ Yes □ No	Liver Disease, Hepatitis(A B C)	□ Yes □ No
Slow or Rapid heart rate	□ Yes □ No	Specific skin disease (type_____)	□ Yes □ No
Arthritis or Lupus	□ Yes □ No	Dry, peeling, itching, flaking skin	□ Yes □ No
Diabetes, thyroid or hormone disease	□ Yes □ No	Stroke, nerve problems	□ Yes □ No
Severe headaches/migraines	□ Yes □ No	Skin Cancer: if yes what type _____	□ Yes □ No

Other cancer: □ Yes □ No if yes, what type? _____

I understand the information above is an important part of my medical care and have answered all of the above questions truthfully and to the best of my ability.

I have been provided a copy of the office HIPPA policy to review and understand a copy is available to me upon request

_____

Signature (Parent or Guardian if Patient is a Minor) Date