

# MOSKOWITZ DERMATOLOGY, M.D., P.L.L.C. DERMATOLOGY MEDICAL HISTORY

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

MEDICATIONS (Include OTC's & Aspirin)
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____

ALLERGIES
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

SOCIAL HISTORY / VACCINATION HISTORY
Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Drinks/Day
Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Packs/Day
Have you received the pneumococcal vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No

FEMALES
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No    Due Date _____

SKIN HISTORY
Have you ever had skin cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No    Type _____
Has anyone in your family had skin cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No    Type _____
Do you have problems with healing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you develop abnormal scars? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you bleed easily? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have sensitivity with local anesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have now, or have you ever had diseases or conditions of:			
High Triglycerides/High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer (If Yes, What type?) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke/T.I.A.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recent Significant Change in Energy <input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recent Unintentional Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heart Beat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bladder/Urinary/Prostate Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker or Defibrillator	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gastrointestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema/Chronic Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Yeast Infection with Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis or Joint Pain <input type="checkbox"/> Yes <input type="checkbox"/> No
HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Convulsions, Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis (If yes; What type and has it been treated?) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Artificial Joints, Pins, Rods, etc (If Yes, List) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
List any other Diseases or Conditions: _____			
List any Surgical Procedures: _____			

Reason for today's visit: \_\_\_\_\_

What is your occupation? \_\_\_\_\_ Hobbies: \_\_\_\_\_

What do you like to be called? \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Reviewed By: \_\_\_\_\_  
*Patient Signature* \_\_\_\_\_ Jeffrey Moskowitz, M.D. \_\_\_\_\_ Elana Shackelford, A.P.R.N.  
 Brooke Gregory, A.P.R.N.  
 Alicia Nuñez, A.P.R.N.