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. _____

DRUG ALLERGIES

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

SOCIAL HISTORY / VACCINATION HISTORY

Alcohol? ❑ Yes ❑ No _____ Drinks/Day

Smoke? ❑ Yes ❑ No _____ Packs/Day

Have you received the pneumococcal vaccine? ❑ Yes ❑ No

FEMALES

Are you pregnant? ❑ Yes ❑ No Due Date ____/____/____

SKIN HISTORY

Have you ever had skin cancer?	❑ Yes	❑ No	Type _____
Has anyone in your family had skin cancer?	❑ Yes	❑ No	Type/Whom _____
Do you have problems with healing?	❑ Yes	❑ No	_____
Do you develop abnormal scars?	❑ Yes	❑ No	
Do you bleed easily?	❑ Yes	❑ No	
Do you have sensitivity with **local** anethesia?	❑ Yes	❑ No	

Do you have now, or have you ever had diseases or conditions of:

High Triglycerides/High Cholesterol	❑ Yes	❑ No	Cancer (If Yes, What type?) _____	❑ Yes	❑ No
Stroke/T.I.A.	❑ Yes	❑ No	Recent Significant Change in Energy	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Recent Unintentional Weight Loss	❑ Yes	❑ No
Heart Attack	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No	Thyroid Disease	❑ Yes	❑ No
Irregular Heart Beat	❑ Yes	❑ No	Kidney Disease	❑ Yes	❑ No
Blood Clots	❑ Yes	❑ No	Bladder/Urinary/Prostate Disease	❑ Yes	❑ No
Pacemaker or Defibrillator	❑ Yes	❑ No	Gastrointestinal Disease	❑ Yes	❑ No
Emphysema/Chronic Bronchitis	❑ Yes	❑ No	Yeast Infection with Antibiotics	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Arthritis or Joint Pain	❑ Yes	❑ No
HIV	❑ Yes	❑ No	Convulsions, Epilepsy or Seizures	❑ Yes	❑ No
Hepatitis	❑ Yes	❑ No	Artificial Joints, Pins, Rods, Mesh, etc	❑ Yes	❑ No
(If yes; What type and has it been treated?)_____			Anxiety	❑ Yes	❑ No
			Depression	❑ Yes	❑ 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.