Charlotte Dermatology
A tradition of care since 1939

Charlotte Dermatology Medical History

Patient Name: ____________________ Date of Birth: ____/____/_____ Reason for visit: _______

Race: __________________ Height/Weight: ______/_____ EMAIL: ________________________

Pharmacy (Name & Address): _____________________ Primary care provider: _______________

Medications

____

____

Allergies

____

____

Review of Systems: Are you *currently* experiencing any of the following: **(Circle all that apply)**

History of melanoma
Bleeding problems
Scarring problems
Rash
Immunosuppression
Hay fever
Chest pain
Fever or chills
Night sweats
Weight loss

Thyroid problems
Sore throat
Blurry vision
Abdominal pain
Joint aches
Muscle weakness
Neck stiffness
Headaches
Seizures
Cough

Shortness of breath
Wheezing
Anxiety
Depression
High blood pressure
Diabetes
Yeast infections with antibiotic use

Alerts:

Adolescent Vaccine:

Three HPV vaccines
One Tdap
One dose of meningococcal vaccine
NONE

Alerts (Circle all that apply)

Allergy to adhesive
Allergy to lidocaine
Allergy to antibiotic ointments
Allergy to latex
Artificial heart valve
Artificial joints in past 2 years

Blood thinners
Defibrillator
MRSA
Pacemaker
Medication before procedures

Rapid heartbeat with epinephrine
HIV
Hepatitis
NONE

Past Medical History: ____

Family Medical History: ____

Previous Surgeries: ____

Skin History (Circle all that apply)

Acne
Actinic keratosis
Skin cancer
Precancerous moles

Eczema
Malignant melanoma
Itchy scalp
Psoriasis

Sunburn
Family history of melanoma
NONE

Social History

Smoking Habits **(Circle one)**	Never smoker	Former smoker	Current smoker
Have you EVER received the pneumonia vaccine?	YES	NO	
Did you get the flu vaccine this year?	YES	NO	
Does someone else make your healthcare decisions?	YES	NO	
Are you pregnant, breastfeeding, or currently planning a pregnancy?	YES	NO	