LAMONT W. HORNBECK, M.D.
CLINICAL DERMATOLOGY AND CUTANEOUS SURGERY

Medical History (For Dermatology Appointment)

Patient Name: _____ Date of Birth: ___/___/___ Today's Date: ___/___/___

List all medications and dosage you are currently taking:
1: _____
2: _____
3: _____
4: _____
5: _____

List all topical medications (creams, etc.) you are using:
1: _____
2: _____
3: _____
4: _____
5: _____

SKIN HISTORY:

Have you ever visited a dermatologist? □ Yes □ No When? _____ Reason? _____

Have you ever had skin cancer? □ Yes □ No If yes, what kind? _____

Do you have a history of any other skin diseases? □ Yes □ No If yes, explain: _____

GENERAL MEDICAL: Do you have now, or have you ever had:

	Yes	No		Yes	No		Yes	No
Asthma	□	□	Seizures	□	□	Arthritis	□	□
Seasonal Allergy	□	□	Depression	□	□	Ulcers/ Reflux	□	□
High Blood Pressure	□	□	Thyroid Disease	□	□	Lip/Fever Blisters	□	□
Heart Valve Disease	□	□	Diabetes	□	□	HIV Infection	□	□
Phlebitis	□	□	Glaucoma	□	□	Cancer	□	□
Blood Clots	□	□	Cataracts	□	□	Hepatitis	□	□
Measles	□	□	Pneumonia	□	□	Colitis/ Bowel Disease	□	□
Polio	□	□	Tuberculosis	□	□	Gallbladder Disease	□	□

Drug allergies? □Yes □No Please list: _____ Food allergies? □Yes □No Please list: _____

List any surgical procedures you have had:

Type of Surgery _____ Date: _____ Type of Surgery _____ Date: _____

Type of Surgery _____ Date: _____ Type of Surgery _____ Date: _____

SOCIAL HISTORY:

	Yes	No		Yes	No
Do you smoke cigarettes?	□	□	Do you drink alcohol?	□	□
Have you ever had local or dental anesthesia?	□	□	Do you need to take antibiotics before dental appointments?	□	□
Any bad reaction?	□	□	Are you pregnant or breastfeeding?	□	□

What is your occupation? _____

FAMILY HISTORY:

Do you have any family history of skin cancer, melanoma, or skin disease? □ Yes □ No If yes, what type? _____

	If Living		If Deceased	
	Age	Health	Age at death	Cause
Father				
Mother				
Sibling 1.				
2.				
3.				

Completed by: _____ Date: _____
Patient/ Parent (Signature)