Menlo Dermatology Medical Group History & Physical

Patient Name: Date Of Birth: Date:

Do you have now, or have had in the past, any of the following: (check if applicable)

☐ Asthma	☐ Arthritis	☐ Kidney Disease	☐ Cancer *Type:* _____
☐ Eczema	☐ Bleeding Tendencies	☐ Liver Disease	
☐ Hair Loss	☐ Diabetes	☐ Thyroid Disease	☐ Previous Surgery(s):_____
☐ Hay Fever	☐ Glaucoma	☐ Seizures	
☐ Hives	☐ Headaches	☐ Stomach or Bowel Disease	
☐ Previous Skin Cancers	☐ Heart Disease	☐ X-Ray Therapy	*FEMALES:*
☐ Psoriasis	☐ Hepatitis	☐ Other	☐ Menstrual Irregularity ☐ Pregnancy
☐ Thick Scars	☐ Herpes (Cold Sores)		☐ Birth Control Past / Present

Are you allergic to any medications? If yes list: _____

Is there any family history of skin disease? If yes describe: _____

BELOW FOR STAFF USE ONLY

HISTORY OF PRESENT ILLNESS:

PAST MEDICAL HISTORY:	FAMILY HISTORY:

PHYSICAL EXAMINATION:	ASSESSMENT:	RECOMMENDATION:

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