



NORTHAMPTON  
**Dermatology**  
 ASSOCIATES

**Medical History** (Please print clearly)

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

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

Are you allergic to any medications? If yes, list: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Type of allergic response: rash, hives, breathing problem. 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Are you allergic to anything other than a medication?  If yes, list: \_\_\_\_\_

List all medications you are currently taking:

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

Current or past problems with:	Yes	No	If yes, please explain
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, nose, throat, mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart, circulation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs, breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach, bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidneys, urinary tract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis, muscles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid, diabetes, hormones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood, bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies, immune system	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nervous system	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are you:  Married  Single  Live alone  Pregnant

Do you smoke?  If so, how much \_\_\_\_\_

Do you drink alcohol?  If so, how much \_\_\_\_\_

Your occupation? \_\_\_\_\_ Your hobbies? \_\_\_\_\_

Have you ever had a skin condition?  If so, what \_\_\_\_\_

Have you ever had a skin cancer?  If so, when and where \_\_\_\_\_

Has anyone in your family ever had a skin condition?  If so, what kind \_\_\_\_\_

Has anyone in your family ever had a skin cancer?  If so, what kind \_\_\_\_\_

\_\_\_\_\_  
 Patient Signature Physician Signature Date