DR. ERIC FINZI & ASSOCIATES
General & Cosmetic Dermatology

Chevy Chase Cosmetic Center • 240-482-2555 | Dermatology & Cosmetic Surgery Associates • 301-345-7375

MEDICAL HISTORY FORM

Patient Name: ______________________________ **Date of Birth:** ____/____/____

Reason(s) for today's visit: ______________________________

Do you currently have or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Arthritis	☐	☐

Cardiovascular:	YES	NO
Anemia	☐	☐
High Blood Pressure	☐	☐
Heart Murmur	☐	☐
Mitral Valve Prolapse	☐	☐
Irregular Heartbeat	☐	☐
Inflammation of Veins	☐	☐
Blood Clots	☐	☐
Pacemaker	☐	☐
Organ Transplant	☐	☐

Other Systemic:	YES	NO
Diabetes	☐	☐
Thyroid	☐	☐
Kidney Disease	☐	☐
Artificial Joint	☐	☐
Epilepsy or Seizures	☐	☐
Pulmonary Disorders	☐	☐
Neurological Disorders	☐	☐
Gastrointestinal Disorders	☐	☐
Autoimmune Disorders	☐	☐
HIV +	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐

Last Pneumonia Vaccination ____________________

Last Flu Shot Date:____________________

Please list any other diseases, chronic conditions, or surgical procedures performed in the last 6 months:

____

Skin History:

			If yes, please explain (cancer type, year diagnosed, treated, etc.)
Have you ever had skin cancer?	☐ YES	☐ NO	________
Has anyone in your family had skin cancer?	☐ YES	☐ NO	________
Do you have a history of any specific skin diseases?	☐ YES	☐ NO	________
Do you have problems with healing?	☐ YES	☐ NO	________
Do you develop keloids (scars) after surgery?	☐ YES	☐ NO	________
Do you bleed easily?	☐ YES	☐ NO	________

Do you develop skin rashes as a reaction to the following:

☐ Medication ☐ Food ☐ Environment ☐ Bandages ☐ Topical Ointments ☐ Neosporin ☐ Other ____________

Social History:

Do you drink alcohol?: ☐ YES ☐ NO (If yes, how per day?: ____) Do you smoke? : ☐ YES ☐ NO (If yes, how per day?: ____)

Female patients: Are you pregnant?: ☐ YES ☐ NO Are you breast feeding? ☐ YES ☐ NO

Form Completed By: ______________________________ **Date:** ____/____/____

Provider / Nurse Signature:______________________________ **Date:** ____/____/____