

Johnson Dermatology Medical History Form

Patient Name: _____	Birthday: _____
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Referring Physician

Did your doctor request that you see us?	Yes	No
If yes, please list your doctor's name: _____		

Health Information

What is the reason for your appointment today?	Skin Growth	Rash	Wart	Acne
Other (please explain): _____				
Where on your body is the condition located? _____				
How long has the condition been present? _____				
Have you had any treatment for this condition, including over the counter products?	Yes	No		
If yes, list those treatments below and whether or not they helped.				
<u>Past Treatment</u>				
_____	Helped	Did Not Help		
_____	Helped	Did Not Help		
_____	Helped	Did Not Help		
<u>Current Treatment</u>				
_____	Helped	Did Not Help		
_____	Helped	Did Not Help		
_____	Helped	Did Not Help		
How would you rate your current overall state of health?	Excellent	Good		
	Fair	Poor		
Do you have any conditions which cause your immune system not to work properly?	No			Yes (please explain): _____
Do you have any medication allergies?	No		Yes (please list below)	
<u>Medication</u>	<u>Reaction</u>			
_____	_____			
_____	_____			
_____	_____			
_____	_____			

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