

Dermatology & Advanced Skin Care, Inc.

Medical History

Patient: _____ Date: _____

Referring Physician: _____

Reason for Today's Visit: _____

List any medications you have used for this condition: _____

Allergies to Medication: None If YES, LIST: 1. _____ 2. _____

Other Allergies: None If YES, LIST: 1. _____ 2. _____

Current Medications: None Aspirin/Motrin/Advil Coumadin Birth Control Pills

Other Medications (Include vitamins and herbal supplements):

1. _____ 2. _____
 3. _____ 4. _____

Do you have or have you ever had problems with:

- | | | |
|---|--|--|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Arthritis | <input type="checkbox"/> YES <input type="checkbox"/> NO Heart Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO Neurological Disease |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Asthma | <input type="checkbox"/> YES <input type="checkbox"/> NO Hepatitis/Liver Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO Psychological Problems |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Blood Disorders | <input type="checkbox"/> YES <input type="checkbox"/> NO High Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO Thyroid Disease |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Diabetes | <input type="checkbox"/> YES <input type="checkbox"/> NO HIV/AIDS | <input type="checkbox"/> YES <input type="checkbox"/> NO Received Blood Transfusions |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Gastrointestinal Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO Lung Disease | |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Hay Fever | <input type="checkbox"/> YES <input type="checkbox"/> NO Kidney Disease | |

Have you had cancer (non skin)? NO YES If YES, what kind? _____

Do you drink alcohol? NO YES If YES, how many drinks per day? _____

Do you use IV drugs? NO YES If YES, what? _____

Do you smoke? NO YES

Do you bleed easily? NO YES

Do you take antibiotics prior to surgery or dental work? NO YES

List any other disease or condition we should know about: _____

List any surgical procedures you have had in the past six months: _____

Skin History:

When exposed to the sun, do you: Tan only Tan and Burn Burn

Have you ever had skin cancer? NO YES Melanoma Squamous Cell Basal Cell

Do you have a history of any specific skin diseases? NO YES If YES, what? _____

Family History (Check any of the following medical conditions that have occurred in your family):

| Disease | Parent | Blood Relative | None | Disease | Parent | Blood Relative | None |
|-----------|--------|----------------|------|-------------|--------|----------------|------|
| Acne | | | | Hay Fever | | | |
| Arthritis | | | | Hives | | | |
| Asthma | | | | Lupus | | | |
| Cancer | | | | Melanoma | | | |
| Diabetes | | | | Psoriasis | | | |
| Eczema | | | | Skin Cancer | | | |

Completed by: Patient _____
 Nurse/Medical Assistant _____ Signed by Physician _____

Continued on reverse side