ADVANCED DERMATOLOGY CARE

Patient Medical History Form

Please Print (If you do not understand or do not have an answer for a question, leave it blank) Date______________________

PATIENT NAME ____
(First) (M) (Last) Birth date Age

Name and location of your regular physician: ____

1. ILLNESS OR CONDITIONS

Are you under the care of a doctor for a specific illness or condition, or have you in the past been treated for: **NONE**

	yes	no		yes	no		yes	no
Blood	____	____	Collagen vascular disease	____	____	Heart problems	____	____
Anemia	____	____	Lupus	____	____	Artificial valve	____	____
Cancer	____	____	Scleroderma	____	____	High blood pressure	____	____
Bone & Joint	____	____	Fibromyalgia rheumatica	____	____	Murmur	____	____
Arthritis	____	____	Dermatomyositis	____	____	Swelling of legs	____	____
Artificial joints	____	____	Kidney	____	____	Nervous system	____	____
Chem dependency	____	____	Liver	____	____	Pregnant/Nursing past/now	____	____
Cold sores	____	____	Lungs	____	____	Stomach or bowel	____	____
Diabetes	____	____	Mental Illness	____	____	Thyroid	____	____

Explain above and any other disease or conditions:____

____

Personal or family history of the following: **NONE**

Abnormal scars	____	____	Eczema	____	____	Psoriasis	____	____
Asthma	____	____	Hay fever	____	____	Skin cancer	____	____
Basal cell carcinoma	____	____	Melanoma	____	____	Squamous cell carcinoma	____	____

Explain above or other: ____

2. OCCUPATION:______________________________ Exposures: ___Chemical ___Sun ___Other______________________

3. HOSPITALIZATIONS (Please list any illness or operation you have had in the past 5 years requiring hospitalization): **NONE**

____ Date: ___________________

____ Date: ___________________

4. BLOOD CONDITIONS **NONE**

a. Have you had hepatitis? No Yes Date________________

b. Have you had any blood transfusions in the last 10 years? No Yes Date________________

c. Do you have any blood clotting or bruising problems? No Yes Explain______________________________

5. MEDICATIONS **NONE** **What pharmacy do you use?** ___________________________ **Ph#:**_______________

a. What medications are you currently taking?____

____

b. Do you use "over-the-counter" medications? No Yes Please list: ______________________________

____

6. ALLERGIES / SENSITIVITIES **NONE**

a. Are you allergic to any medications? No Yes Please list with reaction: ______________________________

____

b. Any history of sensitivity to lidocaine / epinephrine / latex? No Yes Reaction:______________________________

c. Foods? No Yes Please list: ____

d. Hayfever? No Yes (to what)____

7. Do you smoke? No Yes If yes, how many packs/day?_______How many years?_______ If you quit, when?__________

8. Do you drink alcoholic beverages? No Yes If yes, how much? ______________________________

Healthcare Practitioner use only: Date/Drs. Initials	Patient use only: Date/Initials
________________ ________________ ________________	________________ ________________ ________________

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