Associates In Dermatology

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MEDICAL HISTORY

Name ____ **Chart #** __________________ **Date** _____________

Reason for today's visit: ____

List Current Medications: ____

____

Pharmacy: ____ Telephone: ___________________________

Do you have a Heart Pacemaker or Defibrillator? □ **Yes** □ **No**

<u>Blood Thinners</u>

□ Aspirin □ Advil / Ibuprofen □ Aggrenox □ Brilenta
□ Eliquis □ Pradaxa □ Plavix □ Coumadin/Warfarin
□ Xarelto □ Fish oil □ Ginko □ Vitamin E

Other: ____

<u>Medicine Allergies</u>

□ Lidocaine □ Novocaine □ Epinephrine □ Keflex
□ Penicillin □ Tetracycline □ Sulfa □ Erythromycin
□ Aspirin □ Neosporin □ Polysporin

Others: ____

<u>Current and Past Medical Conditions</u> □ Arthritis □ Asthma □ Alzheimer/Dementia

□ Bronchitis □ Convulsions □ Diabetes □ Easy Bleeding □ Emphysema
□ Eczema □ Epilepsy □ Fainting □ Heart Attack □ Heart Valve Replace
□ Hepatitis □ High Blood Pressure □ HIV (AIDS) □ Stroke □ Irregular Heart Beat
□ IV Drug Use □ Joint Replacements □ Liver Disease □ MVP (Mitral Valve Prolapse)
□ Phlebitis □ Stomach Ulcers □ Thyroid Disease □ Tuberculosis

□ Skin Cancer, what type? _________________________________ □ Cancer, what type? ________________________

Others: ____

Are you pregnant? □ **Yes** □ **No** If yes, _____________Months

<u>Has a blood relative had Skin Cancer?</u> If yes, who and what kind? _______________________________________

____ If not patient, please indicate relationship: __________________
Signature of Patient or Legal Representative

Physician Signature: ____ **Date:** __________________

Diplomates, American Board of Dermatology

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