

CENTER FOR ADVANCED DERMATOLOGY

Medical History

Patient: _____ Date of Birth: _____ Today's Date: _____

Reason for today's visit: _____ Age: _____

Are you allergic to any medications? Yes No If yes, list below:

1. _____ 2. _____

Have you ever had numbing done at a dental office? Yes No Any bad reaction? Yes No

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (check YES/NO & Circle if Necessary)

Lungs:	Yes	No	Other Systemic:	Yes	No
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid: _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney: _____	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:	Yes	No	Gastrointestinal (circle if applicable)		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea, yeast		
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Infections when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Special Needs	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorder (Bipolar, Depression, Schizophrenia, Dementia)	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases, conditions, or cancers: _____

List surgical procedures you have had in the last year: _____

Skin: When you are exposed to the sun do you: Tan Only Tan and Burn Burn.
Have you ever had skin cancer? Yes No Type? _____
Has anyone in your family had skin cancer? Yes No Who & Type? _____
Do you have a history of any specific skin diseases? Yes No Type? _____
Do you have problems with healing? Yes No
Do you develop keloids (thick scars) after surgery? Yes No
Do you bleed easily? Yes No
Do you develop skin rashes in reaction to Medication Food Environment Bandages Topical Neosporin
 Other _____

Social History:

Do you drink alcohol? Yes No If YES, drinks per day? _____ Per week? _____
Do you use recreational/illicit drugs? Yes No If YES, what? _____ How often? _____
Do you use tobacco products? Yes No If YES, how much? _____
Have you ever had or have you been exposed to HIV (AIDS)? Yes No

(Women) Are you or are you planning to be pregnant? Yes No Due Date: _____

What is your occupation? _____ Hobbies? _____

Form Completed by: _____ (Initials of Medical Staff Reviewing From: _____ Date _____)

(Reviewed On: _____ Init: _____ Reviewed On: _____ Init: _____ Reviewed On: _____ Init: _____)

Aesthetic Patients Please Complete Reverse Side