

AFFILIATED DERMATOLOGISTS, S.C. MEDICAL HISTORY

Date: _____ Acct #: _____
(office use) (Provider)

Name: _____
Last First Middle Birthdate

Occupation: _____

Primary MD: _____ Referring MD: _____

Pharmacy: _____ / _____ / _____
Name Address Phone

Mail Order Pharmacy: _____

Allergies: _____

**Current Prescribed Medications
Include Birth Control Pills**

**Over-the-Counter Supplements and
Current Over-the-Counter Medications**

Do you have now, or have you ever had:

	Yes	No		Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	History of cancer(non-skin)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	If yes, type: _____		
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Personal history of Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Basal cell carcinoma		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Squamous cell carcinoma		
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/> Melanoma		
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>				Family history of melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>				If yes, relationship to patient:	_____	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>						
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>						

Joint Replacement If yes, specify Joint _____; Replacement Year _____

Do you need to take antibiotics before dental work? Yes No

Other Medical Conditions – Please Explain: _____

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker

For Office Use Only

Skin Type: _____