AFFILIATED DERMATOLOGISTS, S.C. MEDICAL HISTORY

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

Name: _____ _____
Last First Middle Birthdate

Occupation: _____ **Patient's Employer:** _____

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
Asthma	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Pacemaker	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Kidney Disease	☐	☐
Thyroid Disease	☐	☐
Diabetes	☐	☐
Ulcers	☐	☐

	Yes	No
Tuberculosis	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
HIV	☐	☐

	Yes	No
History of cancer(non-skin)	☐	☐
If yes, type: _____		
Personal history of Skin Cancer	☐	☐
☐ Basal cell carcinoma		
☐ Squamous cell carcinoma		
☐ Melanoma		
Family history of melanoma	☐	☐
If yes, relationship to patient: _____		

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: _____