

MEDICAL HISTORY



**Advanced Dermatology
& Cosmetic Surgery**

The doctors and staff of Advanced Dermatology & Cosmetic Surgery are pleased that you have chosen us for your healthcare needs. Please complete this form so we may better serve you. The information you provide will assist us in attending to your healthcare needs more effectively and efficiently. It is important that you provide us with any changes or updates (address, insurance company, etc.) each time you see us. For more information about the products and services we offer, please speak with a member of our staff.

Patient _____ Date _____

Reason for today's visit _____

Do you have now, or have you ever had diseases or conditions of: (If yes, please check box)

Lungs

- Bronchitis Emphysema Asthma Chronic Cough Morning Cough

Vascular

- High Blood Pressure Chest Pain Heart Attack Heart Murmur Irregular Heartbeat
 Pacemaker Blood Clots/Phlebitis Mitral Valve Prolapse

Other Systemic

- Diabetes Thyroid Kidney Bladder Stomach
 Bowel Hepatitis A/B/C Glaucoma Arthritis/Joint

Current Medication

- Do you have any allergies to food or medicine? Y N If yes, please list _____
Do you currently use any prophylactic antibiotics? If yes, please list _____
Do you drink alcohol? (If yes, what) _____ | Amt per day _____
Do you currently use IV drugs? (If yes, what) _____ | Amt per day _____
Do you currently take any medications? If yes, please list _____
Have you ever been exposed to HIV/AIDS? Have you ever had a blood transfusion? Y N
Have you ever had dental anesthesia (Novacaine)? Any Adverse reaction? Y N
Are you latex intolerant?

Skin

- Have you ever had skin cancer? Y N (If yes) Location(s) _____
Family history of skin cancer? Relationship: _____
Relationship: _____ Relationship: _____
Do you currently use skin care products? (If yes, what) _____
When exposed to sun, do you: Tan Tan & Burn Burn

List any other disease or condition we should be aware of: _____

List surgical procedures performed within the last 6 months: _____

Please answer the following questions.

- | | |
|---|--|
| A. Do you smoke? Y <input type="checkbox"/> N <input type="checkbox"/> | B. Do you bleed easily? Y <input type="checkbox"/> N <input type="checkbox"/> |
| C. (Women) Are you pregnant? Y <input type="checkbox"/> N <input type="checkbox"/> | D. Do you have artificial joints, pins or screws? Y <input type="checkbox"/> N <input type="checkbox"/> |
| If no, date of last menstrual period _____ | E. Do you require antibiotics prior to surgery? Y <input type="checkbox"/> N <input type="checkbox"/> |

F. What is your occupation? _____

Completed by: Patient _____ (initial) Signed by Physician _____ Date _____
Nurse _____ (initial) Reviewed by _____ Date _____
M.A. _____ (initial)

Preferred Pharmacy _____

Location _____ **Pharmacy Phone Number** _____

02182c 5/02

Nurse _____ (initial) M.A. _____ (initial) Reviewed by _____ (initial) Date _____