MEDICAL HISTORY

ADVANCED DERMATOLOGY and Cosmetic Surgery

The doctors and staff of Advanced Dermatology & Cosmetic Surgery are pleased that you have chosen us for your health care 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 Clot/Phlebitis ☐ Mitrel Valve Prolapse

Other Systemic

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

Current Medication	**Y**	**N**	If yes,
Do you have any allergies to food or medicine?	☐	☐	please list
Do you currently use any prophylactic antibiotics?	☐	☐	If yes, please list
Do you currently 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 medication?	☐	☐	If yes, please list

Have you ever been exposed to HIV/AIDS? ☐ ☐ Have you ever had a blood transfusion? Y ☐ N ☐
Ever had a dental anesthesia (Novacaine)? ☐ ☐ Any Adverse Reaction? Y ☐ N ☐
Are you latex intolerant? ☐ ☐

Skin	Y	N	If yes,
Have you ever had skin cancer?	☐	☐	Location(s)
Family history of skin cancer?	☐	☐	Relationship(s)
Do you currently use skin care products?	☐	☐	(If yes, what)

When exposed to the 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:	Y	N		Y	N
A. Do you smoke?	☐	☐	B. Do you bleed easily?	☐	☐
C. (Women) Are you pregnant?	☐	☐	D. Do you have artificial joints, pins or screws?	☐	☐
If no, date of last menstrual period: _____			E. Do you require antibiotics prior to surgery?	☐	☐

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: _____

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