Medical Dermatology Specialists, Inc.

5730 Glenridge Drive, Suite T-100, Atlanta, GA 30328 (404) 939-9220

PATIENT MEDICAL HISTORY

Patient Name _____ Account # _____ Date _____

Reason for today's visit _____

Who is your primary care physician? _____

Who referred you to us? _____

MEDICAL HISTORY

Please check those medical conditions that apply to you (this information is kept confidential).

____Heart Disease
____Heart Murmur/Artificial heart valve
____Stroke
____ Gastrointestinal Problems
____Hypertension
____Poor Healing
____Diabetes
____Endocrine or Hormone Stroke Problems
____Skin Cancer
____Seizure Disorders
____Cancer
____Herpes Infections
____Arthritis
____Breathing Difficulties
____HIV Positive
____Sexually Transmitted Diseases
____Tuberculosis
____Shingles
____Hepatitis/Liver disease/Jaundice
____Blood Clotting Disorders
____Asthma / Hayfever
____Kidney Disease
____Other (Please explain below)
____Ulcers
____Seasonal Allergies

Please explain any conditions checked above _____

Please list ALL medications you are currently taking (including aspirin, laxatives, birth control pills, vitamins, etc.)

_____

ALLERGIES (list all known allergies to latex, metals, medications, jewelry, etc.)_____

Do you have a family history of skin cancer? If so what type? _____ ____Yes ____No

Have you ever had skin cancer? If so, what type? _____ ____Yes ____No

Do you have any changing or suspicious moles? _____ ____Yes ____No

(Moles with unusual colors or bleeding)? _____ ____Yes ____No

Are you pregnant or nursing? _____ ____Yes ____No

If no to pregnant are you trying to get pregnant? _____ ____Yes ____No

When was your last flu shot? Date? _____

Do you use tobacco? Yes ___No___ (Such as smokeless tobacco products, cigars, or cigarettes) If yes, how much?

_____

Do you drink alcohol? ____Yes ____No

Are you taking a blood thinner, like Coumadin or aspirin? ____Yes ____No

If so, which? _____

Do you have a heart problem or artificial joint that requires you to take antibiotics before a surgical or dental procedure?

____Yes ____No

Do you have a pacemaker? ____Yes ____No

Thank you for your time in completing your medical history. This helps your doctor to keep current with your health. It is our goal to provide you the best care possible.

Patient / Guarantor Signature *_____ Date _____