Tidewater DERMATOLOGY

Medical History

Patient: _____ Date: _____

Primary Doctor: _____ Referring Doctor: _____

Reason for Today's Visit:_____

List any medications you have used for this condition: _____

Medication Allergies: ☐ None If YES, LIST:

1. _____
2. _____
3. _____

Blood Thinners Taken Daily:

☐ Aspirin
☐ Coumadin/Warfarin
☐ Other: Name: _____

Other Medications: include birth control, vitamins, herbal supplements or other over the counter medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medical Alert:

☐ Clindamycin allergy
☐ Doxycycline/Minocycline/Tetracycline allergy
☐ Latex allergy

☐ HIV/AIDS
☐ Hepatitis C

☐ Pacemaker
☐ Defibrillator

☐ Joint Replacement IF YES, year: _____
☐ Heart Valve Replacement
☐ Heart murmur

Skin cancer:
Have you ever had:
☐ Melanoma
☐ Squamous Cell Carcinoma
☐ Basal Cell Carcinoma

Location and Type?	Year?
_____	_____
_____	_____
_____	_____

Skin History:

When exposed to the sun, do you: ☐ Tan only ☐ Tan and Burn ☐ Burn
Do you use sunscreen? ☐ No ☐ Yes IF YES, what SPF sunscreen do you use? _____
Do you currently or have you ever used tanning beds? ☐ No ☐ Yes IF YES, approximately how many sessions? _____

List any other disease or condition we should know about: _____

_____

List any surgical procedures you have had in the last six months: _____

_____

Do you drink alcohol? ☐ No ☐ Yes Do you smoke? ☐ No ☐ Yes Do you use IV drugs? ☐ No ☐ Yes

Do you or a family have any of the following conditions?

Disease	You	Family Member	None	**Disease**	You	Family Member	None
Acne				**Hay Fever**			
Arthritis				**Hives**			
Asthma				**Lupus**			
Cancer				**Melanoma**			
Diabetes				**Psoriasis**			
Eczema				**Skin Cancer**			