Dermatology & Advanced Skin Care, Inc.
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._____

Blood Thinners Taken Daily:

☐ Advil/Aspirin/Motrin

☐ Blood thinner: Type:_____

Other Medications (Include birth control, hormonal device, vitamins, and herbal supplements):

1._____

2._____

3._____

4._____

Medical Alert:

☐ Clindamycin Allergy
☐ Epinephrine Sensitive
☐ Latex Allergy
☐ Lidocaine Allergy

☐ HIV/AIDS
☐ Hepatitis B
☐ Hepatitis C

☐ Pacemaker
☐ Defibrillator

Skin Cancer:

Have you ever had skin cancer? ☐**NO** ☐**YES**

If YES: ☐Melanoma ☐Squamous ☐Basal

Location of skin cancer? Year?

_____ _____

_____ _____

_____ _____

Have you had joint replacement? ☐**NO** ☐**YES** When:_____

Have you had valve replacement? ☐**NO** ☐**YES** When:_____

Have you had cancer (non skin)? ☐**NO** ☐**YES** If YES, what kind?_____

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

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

Do you drink alcohol? ☐**NO** ☐**YES** If YES, how many drinks per day?_____

Do you use IV drugs? ☐**NO** ☐**YES** If YES, what?_____

Do you smoke? ☐**NO** ☐**YES**

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 have a history of any specific skin diseases ☐**NO** ☐**YES** If YES, what?_____