□ BELLM □ LYN
□ HB □ VS
□ KIM

ATLANTIC DERMATOLOGIC ASSOCIATES, LLP
MEDICAL HISTORY

PLEASE PRINT CLEARLY

Name_____**Date**_____

DO YOU REQUIRE PREMEDICATION BEFORE SURGICAL/DENTAL PROCEDURES YES/NO

Today's visit is for:_____

HEIGHT _____ WEIGHT _____

CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDS)	
1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

MEDICAL HISTORY: PLEASE CHECK OR FILL IN ALL PHYSICIAN DIAGNOSED MEDICAL CONDITIONS

□ **Skin Cancer:**
- ○ **Melanoma: Date: _____**
  Location_____
- ○ **Squamous Cell Carcinoma**
- ○ **Basal Cell Carcinoma**
- ○ **Actinic Keratosis (pre-skin cancer)**
- ○ **Other: _____**

□ **Dermatological Disease:**
- ○ **Herpes/ Cold Sores**
- ○ **Psoriasis**
- ○ **Eczema**
- ○ **Acne / Rosacea**
- ○ **Blistering Disorder: _____**
- ○ **Healing problems; slow, keloid, bruising**
- ○ **Other: _____**

□ **Immunological Disease:**
- ○ **Immune Deficiency**
- ○ **HIV / AIDS**
- ○ **Lupus or Scleroderma**

□ **Hematology / Oncology:**
- ○ **Cancer: type: _____**
- ○ **Bleeding Problems**

□ **Rheumatologic Disease:**
- ○ **Osteoarthritis**
- ○ **Rheumatoid Arthritis**
- ○ **Gout**

□ **Psychological / Emotional Disease**
- ○ **Depression**
- ○ **Obsessive - Compulsive**

□ **Gastrointestinal Disease:**
- ○ **Crohn's Disease, Ulcerative Colitis**
- ○ **Esophageal Reflux**
- ○ **Peptic Ulcer**
- ○ **Esophagitis**

□ **Cardiovascular Disease:**
- ○ **High Blood Pressure**
- ○ **Heart Problems: _____**
- ○ **Heart Attack; Date: _____**
- ○ **Pacemaker / A CD**
- ○ **Irregular heartbeat**
- ○ **High Cholesterol**

□ **Endocrine Disease:**
- ○ **Diabetes**
- ○ **Hyperthyroid / Hypothyroid**

□ **Neurological Disease:**
- ○ **Stroke / Aneurysm**
- ○ **Seizure / Epilepsy**
- ○ **Alzheimer's**
- ○ **Fainting**

□ **Liver Disease:**
- ○ **Hepatitis; type:_____**
- ○ **Jaundice**

□ **Lung Disease:**
- ○ **Asthma**
- ○ **COPD**
- ○ **Tuberculosis**

□ **Kidney Disease:**
- ○ **Poorly functioning kidneys**
- ○ **Dialysis; type_____**

□ **For Female Patients:**
- ○ **Are you pregnant / Planning Pregnancy**
- ○ **Polycystic ovarian disease**

□ **Other / Not Listed:**
- ○ _____
- ○ _____
- ○ _____
- ○ _____

MEDICATION ALLERGIES

NAME OF MEDICATION	TYPE OF REACTION
	□ rash □ difficulty breathing □stomach pain/vomiting □ other
	□ rash □ difficulty breathing □stomach pain/vomiting □ other
	□ rash □ difficulty breathing □stomach pain/vomiting □ other

SURGERIES

TYPE OF SURGERY	SURGEON	HOSPITAL	DATE

FAMILY MEDICAL HISTORY (PLEASE ADD ANY OTHERS NOT LISTED)

Conditions / Problems	Family Members affected and exact nature of problems
□ Melanoma	
□ Non-Melanoma Skin Cancer	
□ Blistering Disorder	
□ Auto-Immune Disorder	
□ Psoriasis	
□ Other	

SOCIAL HISTORY / HABITS

□ Occupation _____ □ Retired
□ Smoker: _____packs/day □ Non – smoker □ Quit smoking in _____
□ Smokeless Tobacco:_____
□ Alcohol Use: □ Yes(drinks/week: _____) □ No
□ Recreational Drug Use: □ No □ Yes _____
□ Sunscreen Use: □ Regularly □ Rarely □ Never
□ I have traveled outside the U.S. in the past 3 months:_____

Do you / Have you had
□ Always burn, never tan
□ Usually burn, tan w/difficulty
□ Sometimes burn, usually tan
□ Rarely burn, tan easily
□ At least 1 blistering sunburn
□ Utilize a tanning bed. How often _____

REVIEW OF SYSTEMS: Please mark the symptoms you've been having recently

GENERAL
□ Weight gain / loss
□ loss of appetite
□ fever / chills
□ weakness
□ night sweats

SKIN
□ rash
□ dry/sensitive skin
□ hives
□ suspicious moles
□ suspicious lesion
□ acne
□ itching
□ hair loss

EAR/NOSE/THROAT
□ congestion
□ nosebleed
□sore throat
□ difficulty swallowing

ALLERGY
□ runny nose
□ scratchy throat
□ itchy eyes
□ sinus congestion
□ sneezing

CARDIOLOGY
□ chest pain
□ palpitations
□ leg swelling

MUSCULOSKELETAL
□ joint stiffness
□ leg cramps
□ joint pain
□ joint swelling
□ back pain
□ neck pain
□ muscle aches

RESPIRATORY
□ shortness of breath
□ chest tightness
□ cough
□ wheezing
□ congestion

PSYCHOLOGY
□ depression
□ high stress level
□ eating disorder
□ mood swings
□ obsessive – compulsive tendencies

ENDOCRINE
□ excessive sweating
□ excessive thirst
□ excessive urination
□ heat intolerance
□ cold intolerance

BLOOD/LYMPH
□ swollen glands
□ varicose veins
□ easy bruising
□ anemia
□ lymphedema

EYES
□ decreased vision
□ blurry vision

NEUROLOGY
□ headache
□ tingling / numbness
□ seizures
□ dizziness

GASTROENTEROLOGY
□ nausea
□ vomiting
□ heartburn
□ abdominal pain
□ change in bowel habits

UROLOGY
□ difficulty urinating
□ blood in urine
□ urinary tract infections

PRINT NAME _____

SIGNATURE _____ DATE_____
PATIENT/PARENT/GUARDIAN