DERMATOLOGY
CONSULTANTS OF GLOUCESTER

## MEDICAL HISTORY

PATIENT NAME________________________________ DATE OF BIRTH________________________________

Do you have now, or have you ever had diseases or conditions of:

| **Vascular:** | Yes | No | **Other:** | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| High blood pressure | __ | __ | Stomach | __ | __ | Bladder | __ | __ |
| Artificial heart valve | __ | __ | Bowel | __ | __ | Diabetes | __ | __ |
| Chest pain | __ | __ | Hepatitis | __ | __ | Thyroid | __ | __ |
| Heart attack | __ | __ | Glaucoma | __ | __ | **Lungs:** | | |
| Heart murmur | __ | __ | Arthritis | __ | __ | Bronchitis | __ | __ |
| Irregular Heartbeat | __ | __ | Joint deformity | __ | __ | Emphysema | __ | __ |
| Pacemaker | __ | __ | Artificial joint | __ | __ | Asthma | __ | __ |
| Phlebitis | __ | __ | Epilepsy/seizure | __ | __ | | | |

List all prescribed and over the counter medications you are currently taking:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please list any surgeries:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Are you **allergic** to any medications? Yes __ No__ If yes, please list:

______________________________________________________________________________

______________________________________________________________________________

Do you drink alcohol? Yes__ No__ If yes, how many drinks per day? ______

Do you smoke? Yes__ No__

Do you use IV drugs? Yes__ No__

Have you ever been exposed to HIV (AIDS)? Yes__ No__

Have you ever had dental anesthesia (Novacaine)? Yes__ No__

Do you require antibiotics prior to surgical procedures? Yes__ No__

What is your occupation?________________________________________________

What are your hobbies?__________________________________________________

Skin:

When you are exposed to the sun do you: Tan only__ Tan and burn__ Burn__

Have you or a family member ever had skin cancer? Yes__ Type____________________ No__

Have you or a family member ever had a melanoma? Yes__ No__

Do you have a history of any specific skin diseases? Yes__ No__

If yes, please list:_______________________________________________________

Please list any other diseases or conditions we should know about:

______________________________________________________________________________

______________________________________________________________________________