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:

_____

_____