LIMMER DERMATOLOGY
Your Skin. Our Specialty.

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(210) 496-9929 Fax (210) 496-6699

Medical History

Patient Name: _____ **Date of Birth:** _____

Medical History:

List all medical conditions for which you are being treated (include anything you are currently taking medications to treat)

☐ **See Attached List**

☐ **High Cholesterol** ☐ **Cancer** ☐ **Hypothyroid/Hyperthyroid** ☐ **Seasonal Allergies** ☐ **Migraines**

☐ **High Blood Pressure** ☐ **Diabetes** ☐ **Depression** ☐ **Other (Please list below)**

_____

_____

Do you use tobacco? ☐ **Yes** ☐ **No**

Immunizations:

Flu Vaccination ☐ **Yes** ☐ **No** Date: _____ **Pneumococcal Vaccination** ☐ **Yes** ☐ **No Date:** _____

Shingles Vaccination ☐ **Yes** ☐ **No** Date: _____

Current Medications:

Please include any prescriptions, over the counter drugs, and vitamins/supplements

☐ **See Attached List** ☐ **Not currently taking any medications**

Drug Name	Dosage	Frequency (at bed time, 2x a day, etc.)	Route (Oral, sublingual, injection, nasal spray, topical, other)

Allergies:

☐ **No Known Drug Allergies**

List all medications that you are allergic to:

Drug Name	Reaction (rash, hives, etc.)

_____

Patient Signature (Guardian if applicable) **Date**