Patient Name: _____ **Patient Medical History**

Today's Date: _____ Patient's Date of Birth: _____

Reason for today's visit? _____

Referring Physician: _____ Primary Care Physician: _____

Best phone # to reach you to discuss results: _____ Okay to leave a message? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No If so, which ones? _____

_____

Have you ever had dental anesthesia (Novacaine)? ☐ Yes ☐ No Any bad reactions? ☐ Yes ☐ No

What medications are you taking? (include prescriptions, over-the-counter medicines, vitamins and herbal supplements):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Preferred Pharmacy (Include Location): _____

What is your occupation? _____ Hobbies? _____

PAST MEDICAL HISTORY: Have you ever had any of the following diseases or conditions?

Lungs:	**Yes**	**No**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic cough	☐	☐
Morning cough	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Cardiovascular:		
High blood pressure	☐	☐
Chest pain	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Irregular heartbeat	☐	☐
Phlebitis	☐	☐
Vein inflammation	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systems:	**Yes**	**No**
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Amputation	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Bladder	☐	☐
Frequency/burning	☐	☐
Gastrointestinal	☐	☐
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea from antibiotics	☐	☐
Yeast infection from antibiotics	☐	☐
Arthritis/ Jc antibiotics	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joints	☐	☐
Convulsions, epilepsy, seizures	☐	☐
Fainting	☐	☐

List any other diseases or conditions: _____

_____

List any surgical procedures you have had in the last 6 months: _____

_____

Patient Name: _____

Skin	**Yes**	**No**	
Have you ever had skin cancer?	□	□	
Is there any family history of skin cancer?	□	□	
Do you have problems with healing?	□	□	
Do you bleed easily?	□	□	
Do you develop keloids (scars) after surgery?	□	□	
Do you have a history of any specific skin diseases?	□	□	
If so which ones?: _____			
Do you wear sunscreen?	□	□	If so, what SPF? _____
Do you develop skin rashes in reaction to (check all that apply)			□ medications □ food □ bandages
□ Neosporin □ other: _____			

SOCIAL HISTORY	**Yes**	**No**	
Do you drink alcohol?	□	□	If yes, how many drinks per day? _____
Do you smoke?	□	□	If yes, how many packs per day? _____
Do you use IV drugs?	□	□	
If yes, which ones? _____			How often?: _____
Have you had or been exposed to HIV/AIDS?	□	□	
Are you HIV positive?	□	□	
(Women) Are you pregnant?	□	□	Due date? _____
Breastfeeding?	□	□	

ALERTS	**Yes**	**No**
Are you using a blood thinner?	□	□
Are you experiencing MRSA (resistant staph)?	□	□
Do you experience rapid heart rate with epinephrine?	□	□
Have you used Accutane in the past 6 months?	□	□
Are you allergic to Lidocaine?	□	□
Are you allergic to latex/tape?	□	□
Are you allergic to topical antibiotics?	□	□

Completed by:
Patient or Patient's representative:

Signature: _____ Date: _____ Updated: _____
Print Name: _____

Reviewed by:

Medical Assistant:

_____ Date: _____ Updated: _____

Physician/Provider:

_____ Date: _____ Updated: _____

ATLANTA DERMATOLOGY & LASER SURGERY