ASSOCIATES IN DERMATOLOGY

PATIENT MEDICAL INFORMATION FORM

Patient Name: _____ Date of Birth: _____

Do you have a history of:

No_____ Yes_____ Hayfever, Allergies, Asthma
No_____ Yes_____ Diabetes
No_____ Yes_____ High Blood Pressure
No_____ Yes_____ Skin Cancer
No_____ Yes_____ Heart Problems
No_____ Yes_____ Bleeding Tendencies
No_____ Yes_____ Stomach Ulcers
No_____ Yes_____ Family Hx of Skin Cancer
No_____ Yes_____ Pacemaker/Defibrillator
No_____ Yes_____ Joint Replacement
No_____ Yes_____ Cold Sores
No_____ Yes_____ Thick Scars/Keloids
No_____ Yes_____ Alcohol Dependency
No_____ Yes_____ Drug Dependency
No_____ Yes_____ Smoking
No_____ Yes_____ Previous Surgeries?
If yes, please list below:

_____
_____
_____
_____
_____

Other Medical problems? Please list below:

_____
_____
_____
_____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Female Patients Only:
Are you currently pregnant or breastfeeding?
No_____ Yes_____

Primary care physician (first & last name):

_____
Location: _____

Preferred Pharmacy Name: _____
Location (street & city): _____
Pharmacy Phone #: _____

Allergies to medications? Please list below:

_____
_____
_____

Any other Allergies? (such as foods, pollen)
Please list below:

_____
_____

Please list all prescription & non-prescription medications that you are currently taking.
Please include vitamins & herbal supplements.

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Signature of Patient or Legal Guardian _____ Date: _____