PEACHTREE DERMATOLOGY ASSOCIATES
Serving Atlanta Since 1957

PATIENT MEDICAL HISTORY

Patient Name_____ **MRN#**_____ **Date** _____

Reason for today's visit _

Who is your primary care physician?_____

Who referred you to us? _____

Please check those medical conditions that apply to you (this information is kept confidential).

____Heart Disease
____Heart Murmur/Artificial heart valve
____Stroke
____Pacemaker
____Gastrointestinal Problems
____Hypertension
____Poor Healing
____Diabetes
____Endocrine or Hormone Problems
____Skin Cancer
____Seizure Disorders
____Cancer
____Herpes Infections
____Arthritis
____Breathing Difficulties
____HIV Positive
____Sexually Transmitted Diseases
____Tuberculosis
____Seasonal Allergies
____Shingles
____Hepatitis/Liver disease/Jaundice
____Blood Clotting Disorders
____Asthma / Hayfever
____Kidney Disease
____Ulcers
_____Other (Please explain below)

Please explain any conditions checked above _____

_____

Please list **ALL MEDICATIONS** you are currently taking (including aspirin, laxatives, birth control pills, vitamins, etc.)

Drug name	**Dosage (strength)**	**Frequency taken (ex: daily, as needed)**

ALLERGIES (list all known allergies to latex, metals, medications, jewelry, etc.)_____

_____

DRUG ALLERGIES (list all known) _____

_____

Do you have a family history of skin cancer? _____Yes_____No
If so what type?_____
Do you have changing/suspicious moles? _____Yes ___No
Unusual colors or bleeding? _____Yes_____No
Are you pregnant or nursing? _____Yes _____No
If no to pregnancy, are you trying? _____Yes_____No
1st day of last menstrual cycle?_____
Do you use tobacco/ smokeless tobacco? _____Yes_____No
Frequency? _____
Do you drink alcohol? _____Yes ____No
Frequency?_____
Are you taking a blood thinner like Coumadin or aspirin?
_____Yes_____No
If so, which?_____

Do you have a heart problem or artificial joint that requires you to take antibiotics before a surgical or dental procedure? _____Yes ____No

Have you received the flu vaccine this season?
_____Yes_____No

****65 and older only****
Have you ever had the Pneumonia vaccine?_____Yes_____No
Do you have an Advance Care Directive or living will? ____Yes ____No
Indicate whom you have named as your surrogate decision maker?
_____
(Please ask our front office staff for a free Advance Care Directive, if you don't currently have one)

Thank you for your time in completing your medical history. This helps your doctor to keep current with your health. It is our goal to provide you the best care possible.

Patient / Guarantor Signature *_____Date _____

If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.