PEACHTREE DERMATOLOGY ASSOCIATES
Serving Atlanta Since 1957

PATIENT MEDICAL HISTORY

3286 Northside Parkway NW, Suite 130 Atlanta, GA 30327

Patient Name _____ Account # _____ Date _____

Reason for today's visit _____

Who is your primary care physician?_____

Who referred you to us? _____

MEDICAL HISTORY

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

____Heart Disease
____Heart Murmur/Artificial heart valve
____Stroke
____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
____Other (Please explain below)
____Ulcers

Please explain any conditions checked above _____

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

_____

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

Do you have a family history of skin cancer?____Yes_____No
If so what type? _____.
Have you ever had 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? ____Yes ____No
Do you use smokeless tobacco products, cigars, or cigarettes) If yes, how much?_____.

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
Do you have a pacemaker? ____Yes ____No
Are you interested in Hair Transplantation?____Yes ____No
When was the date of your last Flu shot? _____

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.

Are you interested in learning about our Cosmetic Services? If no, please return this form to our receptionist. If yes, please continue onto the following questions. Thank you.

Are you interested in cosmetic procedures that improve the appearance of fine lines, wrinkles and discoloration? ___Yes ___No
Are you interested in meeting with our cosmetic consultant regarding skin care and skin regimentation? ___Yes _ __No
Are you interested in treatment of facial blood vessels or leg veins using LASER or Sclerotherapy? ___Yes ___No
Are you interested in LASER hair removal? ___Yes ___No