

VACAVILLE DERMATOLOGY

Please fax to (707) 446-2775

Prior to your appointment

MEDICAL HISTORY

Name _____
Last First M.I.

Reason for today's visit _____

How long have you had this problem? _____

Symptoms (how does it bother you?) _____

Treatments you have tried _____

CURRENT MEDICATIONS: including
prescriptions, over-the-counter medications
(including aspirin), Vitamins, and herbal products:

Are you **allergic to any medications?**

Yes No

If yes, list the medication and reaction:

PAST MEDICAL HISTORY - Please check if you have any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Antibiotics before dental work | <input type="checkbox"/> Infectious Disease/Type _____ |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Hospitalizations last year |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Immune suppression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Hay fever / Seasonal allergies | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High blood pressure | _____ |

HISTORY OF SKIN PROBLEMS

Personal	Family	Relation- Family
<input type="checkbox"/> Eczema	<input type="checkbox"/>	_____
<input type="checkbox"/> History thickened scars/Keloids	<input type="checkbox"/>	_____
<input type="checkbox"/> Melanoma	<input type="checkbox"/>	_____
<input type="checkbox"/> Pre-cancers	<input type="checkbox"/>	_____
<input type="checkbox"/> Squamous Cell Carcinoma	<input type="checkbox"/>	_____
<input type="checkbox"/> Trouble healing	<input type="checkbox"/>	_____
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/>	_____

REVIEW OF SYSTEMS - Please check if any current problems and provide details:

General/Overall Health _____

Heart _____

Infections _____

Skin _____

Other _____

WOMEN ONLY - Please check if you are any of the following:

Pregnant

Planning pregnancy

Nursing

SOCIAL HISTORY

Do you drink alcohol? Yes No If yes, _____ drinks per week

Do you smoke? Yes No If yes, _____ cigarettes per day

I certify that the above information, to the best of my knowledge, is correct.

Signature of Patient/Legal Guardian

Date

Signature of Reviewing Physician

Date