DATE: ____/____/____

South Charlotte Dermatology

PATIENT MEDICAL HISTORY

PATIENT LEGAL NAME: _____ DOB: _____

NICK NAME: _____

REASON FOR VISIT: _____

DRUG ALLERGIES

- ☐ Allergies _____, _____, _____, _____, _____
- ☐ No Known Allergies

FAMILY MEDICAL HISTORY

	Yes	No		Yes	No
Psoriasis	□	□	Squamous Cell Carcinoma	□	□
Eczema	□	□	Melanoma	□	□
Basal Cell Carcinoma	□	□	Other_____	□	□

PAST MEDICAL HISTORY

	Yes	No		Yes	No
Asthma	□	□	Diabetes	□	□
Eczema	□	□	Pacemaker/Defibrillator	□	□
Psorlasis	□	□	Coronary Heart Disease	□	□
Keloid	□	□	High Blood Pressure	□	□
Basal Cell Carcinoma	□	□	Neurological Disease	□	□
Squamous Cell Carcinoma	□	□	Kidney Disease	□	□
Melanoma	□	□	Bleeding Tendency	□	□
Lupus	□	□	HIV/AIDS	□	□
Lung Disease	□	□	Anemia	□	□
Thyroid	□	□	Seizures	□	□
Hepatitis A B C	□	□	Other Illness: _____	□	□

- ☐ Previous Surgeries _____, _____, _____, _____

SOCIAL HISTORY

- ☐ Smoke – How Much? _____
- ☐ Former Smoker
- ☐ Use Alcohol – How Much? _____

FOR WOMEN ONLY

- ☐ Birth Control
- ☐ Menstrual Irregularity
- ☐ Pregnant? Due Date _____/_____/_____

MEDICATIONS

_____, _____, _____, _____

_____, _____, _____, _____

PHARMACY INFORMATION

Pharmacy: _____ Name of Street:_____

Form Completed By: _____

Signature: _____