

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	<input type="checkbox"/>	<input type="checkbox"/>	Squamous Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Basal Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

PAST MEDICAL HISTORY

	Yes	No		Yes	No
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Coronary Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Keloid	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Basal Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disease	<input type="checkbox"/>	<input type="checkbox"/>
Squamous Cell Carcinoma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A B C	<input type="checkbox"/>	<input type="checkbox"/>	Other Illness: _____	<input type="checkbox"/>	<input type="checkbox"/>

- 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: \_\_\_\_\_