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"Excellence in Dermatology Care"

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MEDICAL History Update

YOUR NAME: _____ Today's Date: _____

Physician's Name: _____ Phone #: _____ When was your last visit to your physician? _____

When was your last complete physical?_____

Please tell us if you have had any of the following by checking the appropriate box:

- ☐ Bacterial Endocarditis
- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Rheumatic Heart Fever
- ☐ Rheumatic Heart Disease
- ☐ Artificial Heart Valves
- ☐ Congenital Heart Lesion
- ☐ Mitral Valve Prolapse
- ☐ Heart Attack _____ year
- ☐ Angina/ Chest Pain
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Congestive Heart Failure
- ☐ Hemophelia
- ☐ Blood Disease
- ☐ Sickle Cell Anemia
- ☐ Anemia / Blood Problems
- ☐ Excessive Bleeding
- ☐ Asthma
- ☐ Respiratory Disease
- ☐ Shortness of Breath
- ☐ Hay Fever
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Eye Disorders / Glaucoma
- ☐ AIDS
- ☐ Immunosupressive Disorders / ARC
- ☐ Any Artificial Replacement Artificial Knee, Hip, Joint, Pins, Plate
- ☐ Rheumatism / Arthritis
- ☐ Neurological Problems
- ☐ Epilepsy / Seizures
- ☐ Psychiatric Problems
- ☐ Emotional Problems
- ☐ Alcoholism
- ☐ Chemical Dependency
- ☐ Drug Addiction
- ☐ Malignancies
- ☐ Cancers, Tumors, Growths
- ☐ Radiation Treatments
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Dialysis
- ☐ Liver Problems
- ☐ Hepatitis
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcer / Colitis
- ☐ Venereal Disease
- ☐ Herpes
- ☐ Fever Blisters
- ☐ Pregnant ____ months
- ☐ Oral Contraceptives

Please list any ALLERGIES to Drugs, Medications or Anesthetics: _____

Please list any other MEDICAL CONDITIONS not mentioned above: _____

Please list all DRUGS/MEDICATIONS that you currently take: _____

_____ _____

Patient Signature Date