LONG RIDGE DERMATOLOGY

LONG RIDGE DERMATOLOGY, LLC
Medical History

Patient : _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? ❒ YES ❒ NO If yes, list:

1. _____ 2. _____

List all Medications you are currently taking:

1. _____ 3. _____

2. _____ 4. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**	**Other Systemic:**	**YES**	**NO**
Bronchitis	❒	❒	Diabetes	❒	❒
Emphysema	❒	❒	Thyroid	❒	❒
Asthma	❒	❒	Kidney	❒	❒
Chronic Cough	❒	❒	Bladder	❒	❒
Morning Cough	❒	❒	Stomach	❒	❒
			Bowel	❒	❒
Vascular:			Hepatitis or Yellow Skin	❒	❒
High Blood Pressure	❒	❒	Glaucoma	❒	❒
Chest Pain	❒	❒	Arthritis/Joint Deformity	❒	❒
Heart Attack	❒	❒	Convulsions, Epilepsy		
Heart Murmur	❒	❒	or Seizures	❒	❒
Irregular Heart Beat	❒	❒	Fainting	❒	❒
Pacemaker	❒	❒			
Phlebitis	❒	❒			

Do you drink alcohol? ❒ YES ❒ NO If YES _____ drinks per day

Do you use IV drugs? ❒ YES ❒ NO If YES, what? _____ How much? _____

Have you had or have you been exposed to HIV(AIDS)? ❒ YES ❒ NO

Have you ever had dental anesthesia (Novacaine)? ❒ YES ❒ NO Any bad reaction? ❒ YES ❒ NO

Skin:

When you are exposed to sun do you: ❒ Tan only ❒ Tan and burn ❒ Burn

Have you ever had skin cancer? ❒ YES ❒ NO

Has anyone in your family had skin cancer? ❒ YES ❒ NO If YES, Who? _____

Do you have a history of any specific skin diseases? ❒ YES ❒ NO

If yes, please list: _____

List any other disease or condition we should know about: _____

List surgical procedures you have had in the last 6 months: _____

Please answer the following questions:

A. Do you smoke? ❒ YES ❒ NO If yes, how much: _____

B. Do you bleed easily? ❒ YES ❒ NO

C. (Women) Are you pregnant? ❒ YES ❒ NO Due Date: _____

D. Do you have artificial joint(s)? ❒ YES ❒ NO

E. What is your occupation? _____

F. What are your hobbies? _____

Completed by: ❒ Patient

❒ Medical Assistant _____
Initials

_____
Signed by Physician Date

_____
Reviewed by Date