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:

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

_____

HISTORY OF SKIN PROBLEMS

Personal		Family	Relation- Family
❒	Eczema	❒	_____
❒	History thickened scars/Keloids	❒	_____
❒	Melanoma	❒	_____
❒	Pre-cancers	❒	_____
❒	Squamous Cell Carcinoma	❒	_____
❒	Trouble healing	❒	_____
❒	Other (please specify)	❒	_____

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