

**COASTAL DERMATOLOGY**

**PATIENT HISTORY**

**PATIENT:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**ARE YOU ALLERGIC TO ANY MEDICATIONS:**  Y  N **IF YES, PLEASE LIST:**

\_\_\_\_\_

**LIST ALL MEDICATIONS (INCLUDING ASPIRIN) YOU ARE TAKING:** \_\_\_\_\_

\_\_\_\_\_

**ARE YOU TAKING VITAMINS OR HERBAL SUPPLEMENTS:**  Y  N **IF YES, PLEASE LIST:**

\_\_\_\_\_

**HAVE YOU EVER HAD ANY OF THE CONDITIONS BELOW: (PLEASE CHECK YES OR NO)**

	YES	NO		YES	NO
HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	FIBROMYALGIA / RSD	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	MIGRAINES	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS/LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	CHRONIC FATIGUE SYNDROME	<input type="checkbox"/>	<input type="checkbox"/>
H.I.V / A.I.DS	<input type="checkbox"/>	<input type="checkbox"/>	DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU PREGNANT/ NURSING:	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER TAKEN ACCUTANE:	<input type="checkbox"/>	<input type="checkbox"/>

**DO YOU HAVE ANY OTHER DISEASE OR CONDITION NOT LISTED:**

\_\_\_\_\_

**LIST ALL SURGICAL OR COSMETIC PROCEDURES:**

\_\_\_\_\_

**ANY REACTION TO LIDOCAINE / XYLOCAINE / NOVICAINE (LOCAL ANESTHESIA):**  Y  N

**DO YOU HAVE ANY ARTIFICIAL JOINTS OR IMPLANTS:**  Y  N \_\_\_\_\_

**DO YOU DRINK ALCOHOL:**  Y  N **IF YES, AMOUNT** \_\_\_\_\_

**DO YOU USE TOBACCO:**  Y  N **IF YES, AMOUNT** \_\_\_\_\_

**HAVE YOU EVER HAD SKIN CANCER:**  Y  N

**DO YOU HAVE A FAMILY HISTORY OF SKIN CANCER:**  Y  N

**DO YOU USE TANNING BOOTHS OR LAY OUT TO SUNTAN?**  Y  N

**OCCUPATION:**

**OUTDOOR ACTIVITIES:**

\_\_\_\_\_

\_\_\_\_\_