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: ____________________

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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			HIGH BLOOD PRESSURE		
PACEMAKER			FIBROMYALGIA / RSD		
DIABETES			MIGRAINES		
HEPATITIS/LIVER DISEASE			CHRONIC FATIGUE SYNDROME		
H.I.V / A.I.DS			DEPRESSION		
ARE YOU PREGNANT/ NURSING:			HAVE YOU EVER TAKEN ACCUTANE:		

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: ______________________________