PEACHTREE DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC

PATIENT MEDICAL HISTORY

371 E Paces Ferry Rd NE, Ste 900
Atlanta, GA 30305
Tax ID 581089205

Patient Name _____ MRN# _____ Date _____

Reason for today's visit _____

Who is your primary care physician?_____

Who referred you to us? _____

Please check those medical conditions that apply to you (this information is kept confidential).

____Heart Disease   ____Skin Cancer   ____Shingles
____Heart Murmur/Artificial heart valve   ____Seizure Disorders   ____Hepatitis/Liver disease/Jaundice
                                     ____Cancer   ____Blood Clotting Disorders
____Stroke   ____Herpes Infections   ____Asthma / Hayfever
____Pacemaker   ____Arthritis   ____Kidney Disease
____Gastrointestinal Problems   ____Breathing Difficulties   ____Ulcers
____Hypertension   ____HIV Positive   ____ Other (Please explain below)
____Poor Healing   ____Sexually Transmitted Diseases
____Diabetes   ____Tuberculosis
____Endocrine or Hormone Problems   ____Seasonal Allergies

Please explain any conditions checked above _____
_____

Please list **ALL MEDICATIONS** you are currently taking (including aspirin, laxatives, birth control pills, vitamins, etc.)

Drug name	Dosage (strength)	Frequency taken (ex: daily, as needed)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES (list all known allergies to latex, metals, medications, jewelry, etc.)_____
_____

DRUG ALLERGIES (list all known) _____
_____

Do you have a family history of skin cancer?   _____Yes _____No
If so what type?_____

Do you have changing/suspicious moles?   _____Yes ____No
Unusual colors or bleeding?   _____Yes ____No
Are you pregnant or nursing?   _____Yes ____No
If no to pregnancy, are you trying?   _____Yes ____No
1st day of last menstrual cycle?_____
Do you use tobacco/ smokeless tobacco?   ____Yes ____No
Frequency? _____
Do you drink alcohol?   _____Yes ____No
Frequency?_____
Are you taking a blood thinner like Coumadin or aspirin?
                                      _____Yes ____No
If so, which?_____

Do you have a heart problem or artificial joint that requires you to take antibiotics before a surgical
or dental procedure?   ____ Yes ____No

Have you received the flu vaccine this season?
                         ____ Yes ____No

65 and older only
Have you ever had the Pneumonia vaccine? ____ Yes ____No
Do you have an Advance Care Directive or
living will?   ____Yes ____No
Indicate whom you have named as your
surrogate decision maker?

_____
(Please ask our front office staff for a free Advance Care
Directive, if you don't currently have one)

Thank you for your time in completing your medical history. This helps your doctor to keep current with your health. It is our goal to provide you the best care possible.
Patient / Guarantor Signature *_____ Date _____
If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.