PATIENT MEDICAL HISTORY FORM

PEACHTREE DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC

Patient Name_____ **Date** _____

Reason for today's visit_____

Who is your primary care/referring physician? _____

If this is your first visit, how did you hear about us? _____

Please check those medical conditions that apply to you:

- — Arthritis
- — Asthma / Hayfever
- — Blood Clotting Disorder
- — Breathing Difficulties
- — Cancer
- — Chronic Obstructive Pulmonary Disease
- — Coronary Artery Disease
- — Diabetes
- — Endocrine or Hormone Problems
- — Gastrointestinal Problems
- — Heart Disease
- — Heart Failure
- — Heart Murmur
- — Heart valve, artificial
- — Hepatitis
- — Herpes Infections
- — HIV Positive
- — Hypertension
- — Jaundice
- — Kidney Disease
- — Liver disease
- — Pacemaker
- — Poor Healing
- — Seasonal Allergies
- — Seizure Disorders
- — Sexually Trans. Diseases
- — Shingles
- — Skin Cancer
- — Stroke
- — Tuberculosis
- — Ulcers
- — Other (please list below)

Please explain any conditions checked above _____

Please list **ALL MEDICATIONS** you are currently taking (including aspirin, birth control pills, & vitamins). Continue on back of sheet, if needed.

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

ALLERGIES (list all known allergies)_____

DRUG ALLERGIES (list all known medication allergies) _____

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? _____
Are you taking a blood thinner? _____ **YES** **NO**
If so, which one? _____
Do you have a heart problem or artificial joint that requires you to take antibiotics before surgical or dental procedures? _____ **YES** **NO**
Have you been hospitalized in the last 30 days? _____ **YES** **NO**
If so, when? _____

Tobacco Use

Do you use tobacco (in any form)? _____ **YES** **NO**
How frequently? _____

Alcohol Use

Do you drink alcohol? _____ **YES** **NO**
How frequently? _____

COVID-19

Have you been infected with COVID-19? _____ **YES** **NO**
Have you received the COVID-19 vaccine? _____ **YES** **NO**
If yes, which of the vaccines did you receive and when?
_____

Flu Season only (Oct-March)

Have you received the flu vaccine this season? _____ **YES** **NO**

Women only

Are you pregnant or nursing? _____ **YES** **NO**
If not, are you trying to conceive? _____ **YES** **NO**
1st day of last menstrual cycle? _____

65 and older only

Have you ever had the Pneumonia vaccine? _____ **YES** **NO**
If you cannot make your own medical decisions, do you have an Advance Care Directive or a living will? _____ **YES** **NO**
Indicate whom you have named as your surrogate decision maker/healthcare proxy? _____

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.

Revised 03-2021