Dermatology Associates of Coastal Carolina
2145 Country Club RD. Suite 100 Jacksonville, NC 28546 (910) 333-9337

Patient Name: _____ Date of Birth ____/_____/_____

MEDICAL HISTORY

Chart No._____

Do you have a personal history of **ANY** of the following: ***(circle YES or NO)***

Alcohol Use	YES	NO	Hepatitis	YES	NO
Arthritis	YES	NO	If Yes, explain _____		
Artificial Heart Valve	YES	NO	High Blood Pressure	YES	NO
Artificial Joint	YES	NO	HIV Infection	YES	NO
Bleeding Disorder	YES	NO	Implanted Defibrillator	YES	NO
Cancer (other than skin)	YES	NO	Kidney Disease	YES	NO
Type: _____			Liver Disease	YES	NO
Diabetes	YES	NO	Lung Disease	YES	NO
Diagnosed With HIV	YES	NO	Pacemaker	YES	NO
Drug/Narcotic Habit	YES	NO	Positive TB Test:	YES	NO
Glaucoma	YES	NO	If YES, were you treated?	YES	NO
Heart Disease	YES	NO	Tobacco Use	YES	NO
If YES, explain _____					

1. List any other significant illnesses, family histories of skin cancer, or prior surgeries:

_____

2. Do you have a personal history of skin cancer? **YES or NO**
If yes, please explain when, what type & where: _____

3. List ALL medications, **with dosages**, you are presently taking. Include aspirin or any over-the-counter medications:

_____

_____

4. List medication allergies (including Latex) YES **or NO**:_____

5. Do you have side affects from taking antibiotics such as nausea, yeast infections, or vomiting? **YES or NO**

6. Are you Immunosuppressed? Do you take chemotherapy, prednisone, steroids, or medications to prevent the rejection of a transplant? **YES or NO**

7. Do you have a Health Care Proxy? (a document that allows you to appoint another person(s) as your health care agent to make health care decisions on your behalf) **YES or NO**

8. Have you had your Pneumonia vaccination (ages 65 and over) **YES or NO**

Patient Signature: _____ Date: _____/_____/_____