Dermatology Associates of Coastal Carolina
2115 Neuse Blvd. New Bern NC 28560 (252) 633-4461 Fax (252) 633-6016

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
Arthritis YES NO
Artificial Heart Valve YES NO
Artificial Joint YES NO
Bleeding Disorder YES NO
Cancer (other than skin) YES NO
Type: ______________________________
Diabetes YES NO
Diagnosed With HIV YES NO
Drug/Narcotic Habit YES NO
Glaucoma YES NO
Heart Disease YES NO
If YES, explain ______________________

Hepatitis YES NO
If Yes, explain ____________________
High Blood Pressure YES NO
HIV Infection YES NO
Implanted Defibrillator YES NO
Kidney Disease YES NO
Liver Disease YES NO
Lung Disease YES NO
Pacemaker YES NO
Positive TB Test: YES NO
If YES, were you treated? YES NO
Tobacco Use YES NO

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: ______/______/_________