

# MEDICAL HISTORY-POOLE DERMATOLOGY

Please be complete and honest. This information is strictly confidential and used only by the Doctor to evaluate and treat your medical condition.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F  
Cell Phone # \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Email: \_\_\_\_\_

I hereby authorize the physician or their representative to leave laboratory results on my (circle all that apply):  
Home answering machine / Work voicemail / cell phone / email

Reason for today's visit: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

General Health: Poor  Fair  Good  Excellent

Are you **allergic** to any medications?  Yes  No if yes, list: \_\_\_\_\_

List all **Medications** you are currently taking (please include any prescriptions, over the counter products, vitamins, herbals, etc.)

\_\_\_\_\_  
\_\_\_\_\_

**Past medical history**- Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

LUNGS:	YES	NO	OTHER:	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chronic/morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
TB (tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Bowel	<input type="checkbox"/>	<input type="checkbox"/>
			Liver/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
			HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
VASCULAR:			Arthritis/Joint deformity	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker/Artific. valve	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma/Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis/blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>			type _____

## SKIN:

When you are exposed to the sun do you:  Tan, never burn  Tan more than burn  Burn more than tan  Burn, never tan  
Have you ever had **skin cancer**? Yes  No  If yes, what type? \_\_\_\_\_  
Has anyone in your family had **skin cancer**? Yes  No  If yes, who and what type? \_\_\_\_\_  
Do you have a history of specific **skin diseases**? Yes  No  If yes, please list \_\_\_\_\_  
Do you develop keloids (large scars) after injury to the skin? Yes  No  \_\_\_\_\_  
Do you bleed/ bruise easily? Yes  No   
Do you have problems with poor wound healing? Yes  No   
Have you ever had dental or local anesthesia (Novacaine)? Yes  No  Any bad reaction?  Yes  No  
Do you have artificial joint(s)? Yes  No

List any other diseases or conditions: \_\_\_\_\_

List any surgical procedures you have had in the last 1 year: \_\_\_\_\_

Please answer the following questions:

Do you smoke? YES  NO  if yes, how much: \_\_\_\_\_  
Do you drink alcohol? YES  NO  if yes \_\_\_\_\_ drinks per day  
Do you use IV drugs? YES  \_\_\_\_\_ ?NO if yes, what? \_\_\_\_\_ How much   
What is your occupation? \_\_\_\_\_

**FEMALE PATIENTS:** Date of last menstrual cycle \_\_\_\_\_ Are you currently pregnant or could you be pregnant? Y / N  
Type of birth control \_\_\_\_\_ Previous pregnancies \_\_\_\_\_

**ALL PATIENTS:** The above information is accurate and complete to the best of my knowledge. I understand that it is my obligation and responsibility to notify Poole Dermatology of any changes in my medical condition or medications during the course of my medical treatment.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Reviewed by: \_\_\_\_\_