

Patient Medical Form

LAKE LOVELAND DERMATOLOGY, PC

Personal Identification

Title: _____ First: _____ Middle: _____ Last: _____
Nickname: _____ Former Name: _____
Date of Birth: _____ Age: _____ Gender: _____

Section I: Past Medical History (Please circle ALL that may apply and add any not listed)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial Fibrillation	GERD	Melanoma
Bone Marrow Transplant	Hearing Loss	Melanoma-Family History
Breast Cancer	Hepatitis	Prostate Cancer
Colon Cancer	High Blood Pressure	Skin Cancer (Other)
COPD	High Cholesterol	Stroke
Coronary Artery Disease	HIV/AIDS	NONE

List all major surgeries: _____

Do you require antibiotics prior to a surgical procedure? YES NO

Section IV: Social History

- Are you a current or past smoker? No Yes
- If yes, how much? _____

Section V: Medications

Are you taking any medications, vitamins or herbal supplements? No Yes, please list:

Name: _____	Reason: _____
Name: _____	Reason: _____
Name: _____	Reason: _____
Name: _____	Reason: _____
Name: _____	Reason: _____

Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? No Yes, please list:

Section VII: Alerts: (Please circle ALL that may apply and add any not listed)

Allergy to Adhesive	Artificial Heart Valve	Defibrillator
Allergy to Lidocaine	Artificial Joint Replacement	MRSA
Allergy to Topical Antibiotics	Blood Thinners	Pacemaker
		NONE

Do you have a rapid heart beat with epinephrine? YES NO

Are you pregnant or currently trying to get pregnant? YES NO

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____