New Age Dermatology
Medical History

Please Print

Full Name: _____ DOB: ____/____/_____

Home #: (____)_____-_____ Cell #: (____)_____-_____ Work #: (____)_____-_____Ext:____

Who referred you to our office? (Name & Address) _____

Who is your family doctor? (Name & Address) _____

Dermatology History (CC/HPI)

When did you first notice this skin problem? _____

Where is it located? _____

Has this been treated in the past? Yes / No How does it bother you? Itch, painful, bleeds, other_____

Have you ever had any other skin problems? Yes / No If yes, what kind, and when?_____

Medical History

Please list all medications you are taking
(including non-prescriptions, creams, etc.)

Please list medications you are allergic to:

Have you ever had any of the following problems? (please check Yes or No)

Breathing Problems	☐Yes	☐No
TB	☐Yes	☐No
Liver Problems	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Hepatitis	☐Yes	☐No
Diabetes	☐Yes	☐No
Endocarditis	☐Yes	☐No
Kidney Problems	☐Yes	☐No
Mitral Valve Prolapse	☐Yes	☐No
Cancer	☐Yes	☐No

If you checked yes for Cancer, specify type?: _____

Have you ever been diagnosed with any type of Skin Cancer: ☐Yes ☐No

If you answered yes, please list type, and location:_____

Has anyone in your family ever been diagnosed with any type of Skin Cancer?
☐Yes ☐No

If you answered yes, please list who, and what type_____

Have you ever had dental anesthesia? ☐Yes ☐No
(Novacaine, Lidocaine, etc.)
Any bad reaction? ☐Yes ☐No

Do you Smoke? ☐Yes ☐No

Do you drink alcohol? ☐Never ☐Occasionally ☐Frequently

Do you use IV or illegal drugs? ☐Yes ☐No

Have you ever tested positive for HIV? ☐Yes ☐No

Do you have any tattoo(s)? ☐Yes ☐No

Do you have any of the following

Artificial Heart Valve	☐*Yes*	☐*No*
Heart Murmur	☐*Yes*	☐*No*
Pacemaker	☐Yes	☐No
Artificial Joint	☐Yes	☐No

Do you have to take antibiotics before dental or other procedures? ☐Yes ☐No

Please specify _____

Other Symptoms (ROS):

Weight stable: ☐Yes ☐No

Arthritis: ☐Yes ☐No

Energy good: ☐Yes ☐No

General good Health: ☐Yes ☐No

Fever: ☐Yes ☐No

Women

Are you pregnant? ☐Yes ☐No ☐Not Sure

Are you Breast Feeding? ☐*Yes* ☐*No*

(Women only) Menstrual periods regular: ☐Yes ☐No

History of Tanning Bed Use ☐Yes ☐No

_____
Patient's Signature

_____
Elvira Chiritescu, M.D.