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: ***(check YES or NO)***

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

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

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

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

____

____

Do you have a personal history of skin cancer? YES NO
If yes, please explain when, what type & where: ____

List ALL medications you are presently taking. Include aspirin or any over-the-counter medications:

____

____

List medication allergies (including Latex) YES NO:____

Patient Signature: ____ Date: ______/______/_________

_____/_____/_________ **Patient Signature**: _______________________________ _____/_____/_________
Date Updated **Today's Date**

REVIEWED: REVIEWED: REVIEWED:

REVIEWED: REVIEWED: REVIEWED: