

# 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? \_\_\_\_\_ Is it a rash or growth? (Circle)

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

**Women**

Are you pregnant?  Yes  No  Not Sure

Are you Breast Feeding?  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 to be premedicated before Surgical Procedures?  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

**Other Symptoms (ROS):**

Weight stable:  Yes  No

Arthritis:  Yes  No

Energy good:  Yes  No

General good Health:  Yes  No

Fever:  Yes  No

(Women only) Menstrual periods regular:  Yes  No

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Elvira Chiritescu, M.D.