Welcome to Deerfield Dermatology Associates, Ltd.

Date:

PERSONAL MEDICAL HISTORY

Patient Name: _____
Last Name First Name Middle Initial

Birthdate: _____ / _____ / _____ Age**:** _____

Please check YES or NO for conditions you have or have had in the past.

Y N	FAMILY HISTORY	Y N	PERSONAL HISTORY	Y N		Y N		Y N	
☐☐	Basal Cell Carcinoma Relation:_____Date:_____	☐☐	Basal Cell Carcinoma Date:_____	☐☐	Jewelry/Nickel Allergy	☐☐	Gout	☐☐	Kidney Disease
				☐☐	Latex Allergy	☐☐	Cataracts	☐☐	Liver Disease
☐☐	Squamous Cell Carcinoma Relation:_____Date:_____	☐☐	Squamous Cell Carcinoma Date:_____	☐☐	Iodine Allergy	☐☐	Glaucoma	☐☐	Lung Disease
				☐☐	Seasonal Allergies	☐☐	Colitis-diarrhea	☐☐	Mitral Valve Prolapse
☐☐	Melanoma Type:_____ Relation:_____Date:_____	☐☐	Melanoma Date:_____ Type: _____	☐☐	Photosensitivity	☐☐	Diabetes	☐☐	Multiple Sclerosis
				☐☐	Allergic to local anesthetic	☐☐	Epilepsy	☐☐	Pacemaker
☐☐	Eczema Relation:_____	☐☐	History of skin disease Type:_____	☐☐	Cold sores/ Herpes	☐☐	AIDS/ HIV Positive	☐☐	Prostate Problems/ Cancer
				☐☐	Anemia	☐☐	Heart disease	☐☐	Rheumatic Fever
☐☐	Asthma Relation:_____	☐☐	Actinic Keratosis	☐☐	Arthritis	☐☐	Heart surgery	☐☐	Stroke
		☐☐	Precancerous Mole	☐☐	Bleeding disorder	☐☐	Hepatitis	☐☐	Tuberculosis
☐☐	Seasonal allergies Relation:_____	☐☐	Asthma	☐☐	Blood transfusion	☐☐	High Blood Pressure	☐☐	Venereal Disease
		☐☐	Eczema	☐☐	Cancer Type:_____	☐☐	High Cholesterol	☐☐	Tobacco use qty:___ Quit___
☐☐	Psoriasis Relation:_____	☐☐	Hives/ Urticaria	☐☐	Joint replacement:_____	☐☐	Hyperthyroidism	☐☐	Alcohol use per week:_____
		☐☐	Food Allergies:_____	☐☐	Past surgeries:_____	☐☐	Hypothyroidism	☐☐	Other:_____

CURRENT MEDICATIONS: ☐ NONE or list _____

_____

PLEASE LIST ALL MEDICATION ALLERGIES: ☐ NONE _____

PHARMACY NAME:_____**LOCATION:**_____**PHONE NO.:**_____

Physician who referred you _____ Name of General Internist *(if different)*_____