Blue Ridge Dermatology Associates, P. A.

Medical History & Information

Patient Name: Mr. Dr. Miss Ms. Mrs. _____ **Date:** ____/____/____

Age: _____ **Reason for today's visit**: _____

SOCIAL HX: **Occupation:** _____ **Hobby**: _____ **Do you smoke?** N Y **Alcohol use**? N Y ____ **drinks/wk**

FEMALE PATIENTS ONLY: *(circle one)* post menopausal / abstinent / oral contraceptive / patch / tubal ligation / IUD / hysterectomy / vasectomy / condom

FAMILY HX: Do you have any first-degree relatives with a history of malignant melanoma? N Y Other skin cancers? N Y

PAST MEDICAL HX: (*Circle conditions below if apply to YOU*)

Pre-cancerous skin lesions: AK Atypical moles
Skin cancer: BCC SCC Malignant Melanoma

Allergy to local anesthetic	Lupus
Allergy to latex	Kidney disease
History of Hepatitis B or C	Thyroid disease
HIV/Aids	History of TB
Bleeding problems	Fainting
Scarring problems	Glaucoma
Heart disease	Diabetes
Pacemaker or defibrillator	Raynaud's disease
Heart valve replacement	High blood pressure
Joint replacement	Asthma/Hay fever

List other **MAJOR** health issues: _____

MEDICATION ALLERGIES: No Yes (*list*) _____

List name of current ORAL medications Use other side for additional medications	**Today**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**
	DOB	**DOB**	**DOB**	**DOB**	**DOB**	**DOB**	**DOB**	**DOB**
• Are you pregnant?	N Y	N Y	N Y	N Y	N Y	N Y	N Y	N Y
• Are you trying to conceive?	N Y	N Y	N Y	N Y	N Y	N Y	N Y	N Y
• Are you breastfeeding?	N Y	N Y	N Y	N Y	N Y	N Y	N Y	N Y
• Do you take Birth Control Pills?	N Y	N Y	N Y	N Y	N Y	N Y	N Y	N Y
• New medication allergies ***since last visit?***	N Y	N Y	N Y	N Y	N Y	N Y	N Y	N Y
• Any medication changes ***since last visit?***	N Y	N Y	N Y	N Y	N Y	N Y	N Y	N Y
(*Sign each visit*) **Patient Initials -**								
MA/RN Initials -								
MD Initials -								

Circle below if interested in receiving information on any of the following services.

Skin Care Products Facial Peels Laser Hair Removal Facial Vessels Leg Veins Botox™ Fillers