RICHMOND DERMATOLOGY & LASER SPECIALISTS
9816 Mayland Drive Richmond, VA 23233
804.282.8510 FAX 804.285.5750

MEDICAL HISTORY FORM

Patient Name ______________________________ Date ______________

Reason for today's visit: ______________________________

Are you allergic to any medication? Yes ❑ No ❑ If yes, list:

1. ______________________ 2. ______________________

List any Medications you are currently taking:

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

LUNGS	YES	NO
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑

VASCULAR	YES	NO
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Mumur	❑	❑
Irregular Heart Beat	❑	❑
Pacemaker	❑	❑
Phlebitis	❑	❑

OTHER SYSTEMIC	YES	NO
Diabetes	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Bladder	❑	❑
Stomach	❑	❑
Bowel	❑	❑
Hepatitis or Yellow Skin	❑	❑
Glaucoma	❑	❑
Arthritis / Joint Deformity	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

Do you drink alcohol? Yes ❑ No ❑ If yes, __________ drinks per day

Do you use IV drugs? Yes ❑ No ❑ If yes, what? ______________ How much? ______________

Have you had or have you been exposed to HIV (AIDS)? Yes ❑ No ❑

Have you ever had dental anesthesia (Novocaine)? Yes ❑ No ❑ Any bad reaction? Yes ❑ No ❑

SKIN:

When you are exposed to sun do you: ❑ Tan ❑ Tan and burn ❑ Burn

Have you ever had skin cancer? Yes ❑ No ❑

Has anyone in your family had skin cancer? Yes ❑ No ❑ If yes, what? ______________________

Do you have a history of any specific skin diseases? Yes ❑ No ❑

If yes, please list: ______________________________

List any other disease or condition we should know about: ______________________________

List surgical procedures you had in the last 6 months: ______________________________

Please answer the following questions

A. Do you smoke? Yes ❑ No ❑ If yes, how much? ______________

B. Do you bleed easily? Yes ❑ No ❑

C. (Women) Are you pregnant? Yes ❑ No ❑ If yes, Due Date: ______________

D. Do you have artificial joint(s)? Yes ❑ No ❑

E. What is your occupation? ______________________________

F. What are your hobbies? ______________________________

____
Signed by Physician Date

____
Reviewed by Date