



Piedmont Dermatology Center Medical History

Name: _____ Today's Date _____

Reason for today's visit _____

Family/Medical Doctor _____

Who Referred you to this office _____

ALLERGIES: None _____ Yes _____ Please list all allergies: _____

(1) Drug _____ Reaction _____

(2) Drug _____ Reaction _____

(3) Drug _____ Reaction _____

Do you have any other allergies (latex, food, seasonal, other) No _____ Yes _____

Have you ever had a reaction to Novocaine or Lidocaine (i.e., dental numbing medication)

No _____ Yes _____ What happened _____

List any medications that you are currently taking including prescriptions, over the counter, herbal supplements and vitamins:

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

	NO	YES		NO	YES		NO	YES
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	If YES, explain briefly _____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Have you ever had Skin Cancer? No _____ Yes _____ If yes, what type _____

Has anyone in your family had Skin Cancer? No _____ Yes _____ What Kind _____

If so, how were they related to you? _____

Do you have a history of Skin Disease? No _____ Yes _____ What Kind _____

Do you develop Keloid scars after surgery? No _____ Yes _____

Do you have any problems with healing? No _____ Yes _____

Do you drink alcohol? No _____ Yes _____ How Much? _____

Do you smoke? No _____ Yes _____ How Much? _____

If you are female, are you pregnant? No _____ Yes _____ If Yes, what is your due date _____

Last Menstrual Period _____ Post Menopause: Yes _____

Do you require any antibiotic treatment prior to dental work either now or in the past? No _____ Yes _____

If Yes, please list why _____

Your Occupation _____ Hobbies _____

Patient/Guardian Signature _____

Person Completing Form if other than patient _____

Reviewed By _____ Date Reviewed _____