**MIDWEST DERMATOLOGY CLINIC, P.C.**

## MEDICAL HISTORY

NAME_______________________________________DATE_________________________

ADDRESS_________________________________________________________________

CITY______________________STATE____________________ZIP__________________

BIRTHDATE________________AGE__________ SEX_________WEIGHT_____________

MARITAL STATUS: O M O S O W O D PHONE (Home)________________ (Work)____________

OCCUPATION___________________EMPLOYER________________________________

EMPLOYER'S ADDRESS____________________________________________________

EMERGENCY CONTACT: NAME_____________________PHONE__________________

PERSONAL PHYSICIAN: NAME____________________ADDRESS_________________

PROPOSED PROCEDURE____________________________________________________

Please list any medications you are taking. (Include any vitamins, aspirin, eyedrops, topical medications, herbs, health food supplements or diet pills.)

1.__________________________________2.__________________________________

3.__________________________________4.__________________________________

5.__________________________________6.__________________________________

Are you allergic to Latex? __O__NO __O__YES

Are you allergic or had a bad reaction to ANY medication? __O__NO __O__YES
If yes, please explain:

______________________________________________________________________

______________________________________________________________________

Please list any surgical procedures you have had and the type of anesthesia. (For example, general, spinal or local).
1.____________________________________________________________________
2.____________________________________________________________________
3.____________________________________________________________________
4.____________________________________________________________________
5.____________________________________________________________________

Did you have a bad reaction to the anesthesia? __O__NO __O__YES
If yes, please explain:

______________________________________________________________________

______________________________________________________________________

Please list all occasions when you have been hospitalized. (Include reason for hospitalization.)
1.____________________________________________________________________________
2.____________________________________________________________________________
3.____________________________________________________________________________
4.____________________________________________________________________________
5.____________________________________________________________________________

Please check YES or NO to the following questions:

Have you ever had or been treated for any of the following conditions?
(If YES, please explain)

___O___NO___O___YES Heart disease, chest pain or high blood pressure

___O___NO___O___YES An abnormal heart tracing (EKG)

___O___NO___O___YES Chest pain or shortness of breath on exertion (during walking, running or climbing stairs)

___O___NO___O___YES Pacemaker

___O___NO___O___YES Defibrillator

___O___NO___O___YES Fainting or dizzy spells after exercise or after standing quickly

___O___NO___O___YES Recent cold or respiratory infection*, fever*

___O___NO___O___YES MRSA

___O___NO___O___YES Frequent cough or hoarseness

___O___NO___O___YES Smoke ___ packs daily

___O___NO___O___YES Asthma, emphysema, tuberculosis or lung disease

___O___NO___O___YES Abnormal chest x-ray

___O___NO___O___YES Convulsions or epilepsy

___O___NO___O___YES Blackout spells

___O___NO___O___YES Psychiatric or nerve problems

___O___NO___O___YES Kidney disease

___O___NO___O___YES Liver disease, hepatitis A, B or C, or yellow jaundice

___O___NO___O___YES Blood transfusions in the past

___O___NO___O___YES Anemia or low blood count, sickle cell disease

___O___NO___O___YES AIDS or AIDS related complex

| | |
|---|---|
| ___O___NO___O___YES | Bleeding disorders that cause easy bruising, nosebleeds, or excessive bleeding during surgery. |
| ___O___NO___O___YES | Diabetes or low blood sugar<br>How controlled________________________________ |
| ___O___NO___O___YES | Glaucoma<br>How controlled________________________________ |
| ___O___NO___O___YES | Thyroid trouble |
| ___O___NO___O___YES | Hiatal hernia |
| ___O___NO___O___YES | Regurgitation of stomach - acid reflux |
| ___O___NO___O___YES | Frequent diarrhea or vomiting |
| ___O___NO___O___YES | Recent weight gain or loss |
| ___O___NO___O___YES | Arthritis |
| ___O___NO___O___YES | Paralysis |
| ___O___NO___O___YES | Artificial Limbs – Joints |
| ___O___NO___O___YES | Transplant patient |
| ___O___NO___O___YES | Cancer or leukemia |
| ___O___NO___O___YES | Venereal disease |
| ___O___NO___O___YES | Herpes, cold sores, or fever blisters |
| ___O___NO___O___YES | Keloids or large scars after surgery |
| ___O___NO___O___YES | Skin problems, irritations or rashes |
| ___O___NO___O___YES | Allergy to Tape |
| ___O___NO___O___YES | Are you taking a Biologic or High Risk prescription<br>Name: ______________________ |
| ___O___NO___O___YES | If female, are you pregnant?<br>Last menstrual period______________Normal?____________ |
| ___O___NO___O___YES | Drink alcohol or beer<br>__O__Daily __O__Occasionally How much?__________________ |

Do you have any other medical problems we should know about? If so, please explain:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please check YES or NO to any conditions that a direct family member has ever had:

__O__NO__O__YES Reaction to anesthesia Explain:____________________________
__O__NO__O__YES Diabetes
__O__NO__O__YES High blood pressure or heart problems
__O__NO__O__YES Easy bruising or bleeding tendencies

SIGNED____________________________________________________________

**The information you have provided us is necessary for our evaluation.
Thank you for your time.

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