PATIENT MEDICAL HISTORY

DERMATOLOGY ASSOCIATES OF KENTUCKY, P.S.C
250 FOUNTAIN COURT • LEXINGTON, KY 40509
(859) 263-4444 • FAX (859) 254-1814

Date _____ Chart # _____ Name _____

Referring Physician _____ DOB _____ Age _____ Sex _____

Please answer all questions completely.

Please list **all** medications (over the counter and prescriptions) and **all** vitamins, herbal medicines, or dietary supplements that you take and specify what conditions they are for:

Are you **allergic** to any medications? NO ☐ YES ☐ If yes, list: _____

_____

Please list **every** surgery you have had:

Please list **all** of your medical conditions (e.g. asthma, diabetes, high blood pressure, etc.):

Please list the names of **all** of your doctors (family doctor, gynecologist, pediatrician, cardiologist, etc.):

What is your occupation? _____

Have you ever had a history of, or do you currently have any of the following (please check yes or no below):

YES	NO		EXPLAIN IF YES
_____	_____	Arthritis	_____
_____	_____	Diabetes &/or Thyroid condition	_____
_____	_____	Cancer (If yes, please specify type.)	_____
_____	_____	Blood clots / Lymphoma / Leukemia	_____
_____	_____	Skin cancer &/or Melanoma	_____
_____	_____	Excessive scarring or bleeding	_____
_____	_____	Artificial joints or heart valves	_____
_____	_____	Visual problems &/or eye disease	_____
_____	_____	Internal pacemaker or Defibrillator	_____
_____	_____	Liver problems / Hepatitis / Jaundice	_____
_____	_____	Kidney Disease	_____
_____	_____	Asthma &/or Hay fever	_____
_____	_____	Eczema	_____
_____	_____	Depression &/or Mental Illness	_____
_____	_____	Stroke	_____
_____	_____	HIV Disease / AIDS	_____

	YES	NO	
Do you use tanning beds?	_____	_____	If yes, number of times per week: _____
Do you have a family history of asthma, hay fever, or eczema?	_____	_____	
Has anyone in your family had skin cancer?	_____	_____	If yes, explain: _____
Do you use alcoholic beverages?	_____	_____	If yes, how many drinks per week?
			Please circle one: 1-2 3-6 7-14 15 or more
Do you smoke cigarettes or chew tobacco?	_____	_____	If yes, how much? _____
Do you wear sunscreens?	_____	_____	

SIGN HERE

_____ SIGNATURE OF PERSON COMPLETING FORM

_____ RELATIONSHIP TO PATIENT

_____ MD SIGNATURE