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 list **all** medications (over the counter and prescription) that you take and specify what condition they are for:

Please list **all** vitamins, herbal medicines, or dietary supplements, and you reason for taking them:

Please list every surgery you have had:

Do you have allergies? NO ☐ YES ☐ If yes, list: _____

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

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
Has anyone in your family had psoriasis?	_____	_____
Has anyone in your family had acne?	_____	_____
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