Medical History Form

Family Dermatology
5603 Duraleigh Rd., Suite 111, Raleigh, NC 27612
919-791-0840

Date:_____ Chart #:_____
Name:_____ Gender:_____ Age:_____
Patient race:_____ Ethnicity: _____
Preferred language:_____
How did you hear about us (who referred you?) _____
Please list your primary care physician:_____
Please list any other providers you would like your office notes faxed to:_____
_____
Please provide your e-mail for appointment reminders:_____

Reason for today's visit (please limit to 2 problems)
1. _____
2. _____

Have you had an atypical (dysplastic) mole biopsied? _____
Have you had a basal or squamous cell carcinoma? _____
Have you had a melanoma? _____
Has your father, mother, brother, sister, son or daughter had a melanoma? _____
If yes, is there a family history of pancreatic cancer? _____

Women: Are you pregnant? _____
Breastfeeding? _____
Planning Pregnancy? _____

Do you smoke? __Current smoker __Former __Never

Do you now or have you ever had: (Please check what applies)

__Artificial heart valve
__Artificial joint (knee, etc.)
__Pacemaker
__Defibrillator
__Diabetes
__Hypertension
__Hypercholesterolemia
__Lupus
__Arthritis
__Thyroid Disease

__HIV or AIDS
__Hepatitis B
__Hepatitis C
__Pancreatic Cancer
__Radiation Treatment

Please provide a phone number where we can reach you during the day:_____
May we speak with your family members regarding your problems and test results?_____

Please sign below acknowledging you have reviewed our privacy and financial policies (copies are located at the check in desk)._____ _____
Signature Date

Name:_____
Date Of Birth:_____

Are you allergic to latex, lidocaine, or any other medications?_____
Are you allergic to adhesive?_____
List drug(s) and reaction(s):_____
Are you on a blood thinner?_____

List all medications, over the counter supplements and vitamins that you take daily or as needed:
(Include dosage and frequency)

Name	Dose	Frequency

Pharmacy Information

Name:_____
Street Name:_____
City:_____