

Medical History Form
Family Dermatology A Division of Raleigh Medical Group
5603 Duraleigh Road., Suite 111, Raleigh, NC 27612
or
860 Perry Road, Apex, NC 27502
Fax: 919-791-0840

Name: _____ Gender: _____ Age: _____ Chart # (Office Supplies): _____

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 sent to: _____

Please provide your e-mail for appointment reminders: _____

Reason(s) for today's visit:

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? _____

Do you have a history of any other cancer? _____

Do you smoke or use other tobacco? Current smoker Former Never

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

Artificial heart valve

Diabetes

Lupus

Women Please Answer

Artificial joint

Hypertension

Arthritis

Are you pregnant?

Pacemaker

Hepatitis B

Thyroid disease

Breastfeeding?

Defibrillator

Hepatitis C

Planning pregnancy?

HIV or AIDS

Radiation treatment (if so, list body parts): _____

Any other disease or condition we should know about? _____

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? _____

Do you have any cosmetic concerns? _____

Would you like to receive emails about our cosmetic specials? Yes No

Medicare Patients and patients 65+

Name and # of health care proxy if you have one: _____

Do you have a living will? _____

Which best reflects your wishes: Do not resuscitate Do not intubate Initiate all resuscitation measures

Have you received the pneumonia vaccine (Pneumovax)? _____

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

Signature

Date

Pharmacy Information

Name of pharmacy: _____

Street it is on: _____

City it is in: _____