Medical History Form
Family Dermatology A Division of Raleigh Medical Group 5603 Duraleigh Road., Suite 111, Raleigh, NC 27612
860 Perry Road, Apex, NC 27502
2601 Lake Drive Suite 101, Raleigh, NC 27609
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):

			Women Please Answer
__Artificial heart valve	__Diabetes	__Lupus	____Are you pregnant?
__Artificial joint	__Hypertension	__Arthritis	____Breastfeeding?
__Pacemaker	__Hepatitis B	__Thyroid disease	____Planning pregnancy?
__Defibrillator	__Hepatitis C		
__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

Name: ______________________________

Date of Birth: __________________________

Are you allergic to latex, lidocaine, or any other medications?

____

List drug(s) and reaction(s):

____

____

Are you on any blood thinners?

____

List all medications, over the counter supplements and vitamins that you take daily or as needed. Please include dosage and frequency.

Name	Dose	Frequency

Pharmacy Information

Name of pharmacy: ______________________________

Street it is on: ______________________________

City it is in: ______________________________