



HECKER DERMATOLOGY GROUP, P.A.

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MEDICAL HISTORY

Patient Name: _____ Date: _____

Reason for Today's Visit: _____

Do you have now, or have you ever had diseases or conditions of: *(If yes, please check box)*

Lungs:

Bronchitis | Emphysema | Asthma | Chronic Cough | Morning Cough |

Vascular:

High Blood Pressure | Chest Pain | Heart Attack | Heart Murmur |
Irregular Heartbeat | Mitral Valve Prolapsed | Pacemaker | Blood Clots/Phlebitis |

Other Systemic:

Diabetes | Thyroid | Kidney | | Bladder | Stomach | Bowel | Glaucoma |
Joint/Muscle/Arthritis | Cancer |

Yes No

Do you have any allergies to food or medicine? Please List Allergies: _____

Ever had a blood transfusion? _____

Do you drink any alcohol? If yes, what: _____ Drinks per day: _____

Do you currently use IV Drugs? If yes, what: _____

- Have you been exposed to HIV/AIDS? Yes No

Have you ever had dental anesthesia (Novocain)? Any Adverse Reaction?

Are you latex intolerant?

Do you currently take any medications

Medication List: _____

Have you ever had Skin Cancer? **If yes, Location(s):** _____

Any family history of Skin Cancer? **Relationship to patient:** _____

Do you currently use skin care products? **What brand?** _____

Do you smoke?

Do you bleed easily? **What is your occupation?** _____

(Women) Are you pregnant? **When exposed to the sun, do you (Circle One);**

Any artificial joints, pins, or screws? **Tan Tan & Burn Burn**

Require antibiotics prior to surgery?

Pharmacy Number: _____ Pharmacy Address: _____

List any other diseases or conditions we should be aware of: _____

List surgical procedures performed within the last 6 months: _____

Patient Initials: _____