Brookwood Dermatology, P.C.
Medical History

Patient: _____ Date of Birth: ___/___/___ Today's Date: ____/___/___

Reason for today's visit: _____Cell phone#: _____

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below:
1. _____ 2_____ 3. _____ 4. _____
Have you ever had dental anesthesia (Novocaine)? ❑ YES ❑ NO Any bad reaction? ❑ YES ❑ NO

List all medication dosages and frequency you are currently taking (include prescriptions, over-the-counter meds, vitamins, etc.):
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Have you had the following vaccinations, and if so, when?

❑Influenza _____ ❑Pneumonia _____ ❑Shingles _____ ❑Tetanus _____ ❑Tuberculosis _____

Do you currently have or have you previously had any of the following diseases or conditions: (Please check YES or NO)

Respiratory:	**YES**	**NO**
Bronchitis	❑	❑
Emphysema/Shortness of breath	❑	❑
Asthma/Wheezing	❑	❑
Chronic/Morning Cough	❑	❑
Cardiovascular:	**YES**	**NO**
High Blood Pressure	❑	❑
Chest Pain/Heart Attack/ Stroke	❑	❑
Heart Murmur/Irregular Heartbeat	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑
Endocrine:	**YES**	**NO**
Diabetes	❑	❑
Thyroid	❑	❑
Genitourinary:	**YES**	**NO**
Kidney	❑	❑
Bladder	❑	❑
Yeast infections on antibiotics	❑	❑

Gastrointestinal:	**YES**	**NO**
Stomach malabsorption/IBS	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Muskuloskeletal:		
Arthritis/Joint Deformity	❑	❑
Limited motion	❑	❑
Artificial joints	❑	❑
Neurological:		
Seizures, epilepsy, convulsions:		
Constitutional:	**YES**	**NO**
Weight loss/gain	❑	❑
Fever	❑	❑
History of liver disease	❑	❑
Allergic/Immunologic:		
Lupus/Rheumatoid Arthritis	❑	❑
Hepatitis infection/exposure	❑	❑
HIV infection/exposure	❑	❑

List any other diseases or conditions: _____
If female, current method of contraception: _____
List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had skin cancer? ❑ YES ❑ NO
Has anyone in your family had skin cancer? ❑ YES ❑ NO
Do you have a history of any specific skin diseases? ❑ YES ❑ NO
If yes, _____
Do you have problems with healing? ❑ YES ❑ NO
Do you develop keloids (scars) after surgery? ❑ YES ❑ NO
Do you bleed easily? ❑ YES ❑ NO
Do you develop skin rashes in reaction to: ❑Medications ❑Food ❑Environment ❑Adhesive ❑Neosporin ❑Other

Social History:
Do you drink alcohol? ❑YES ❑NO If YES, _____ drinks per day
Do you smoke? ❑YES ❑NO If YES, _____packs per day

Please list the following: Pharmacy Number_____ **Primary care Physician**_____

What is you occupation? _____ Hobbies? _____

How did you hear about us? ❑Patient ❑Friend ❑Physician Referral ❑Other

Reviewed and updated by M.D/P.A. _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____