Manhattan Beach DERMATOLOGY MEDICAL CORPORATION

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Personal Medical History

Name_____ Reason for today's Visit_____

Medication Allergies:_____

Type of reaction_____

NON-MEDICATION ALLERGIES: Latex____ Others (food, tape, etc)_____

DO YOU REGULARLY TAKE ASPIRIN? _ Yes _ No Height _____ Weight_____lbs

CURRENT MEDICATIONS:_____

_____

MEDICAL HISTORY: (check all that apply)

_ Anemia	_ Cataracts	_ Hepatitis (A,B, or C)	_ Pacemaker
_ Arthritis	_ Cholesterol	_ Herpes simplex (cold sores)	_ Psoriasis
_ Artificial Joint	_ Colon/intestinal disorder	_ High Blood Pressure	_ Scarring / Keloids
_ Artificial heart valve	_ Depression	_ HIV disease (AIDS)	_ Thyroid disease
_ Asthma	_ Diabetes	_ Hives	_ Tuberculosis (or symptoms of TB; coughing & fever)
_ Abnormal moles	_ Eczema	_ Kidney Disease / Stones	If yes, are you experiencing any of the following:
_ Bleeding, excessive	_ Epilepsy / Seizures	_ Lung disease	o productive cough o Night sweats o Fatigue o Malaise o Fever o unexplained weight loss
_ Cancer	_ Glaucoma	_ Malignant melanoma	_ Ulcers
type_____	_ Hair loss	_ Mitral Valve Prolapse	_ Warts
_Skin cancer	_ Liver disease	_ Neurological problems	_ Genital Warts
_ Basal Cell Carcinoma	_ Hay Fever / Allergies		
Site_____	_ Heart problems / Murmur		
_ Squamous cell carcinoma			
Site_____			

Other Condition(s) describe_____

Women Only: Birth control method_____ _ Currently pregnant _____wks

_ Actively trying to conceive Number of Children and ages _____

HOSPITALIZATION/SURGICAL HISTORY: (past 2 years)_____

_____

SOCIAL HISTORY: Do you smoke/chew tobacco? _ Yes _ No Drink alcohol _ never _ socially _ daily

FAMILY HISTORY: Is there a history in your family of the following diseases?

_Acne	_ Eczema	_ Malignant Melanoma	_ Tuberculosis
_ Allergies / hayfever	_ Heart disease	_ Psoriasis	
_ Asthma	_ Lung disease	_ Skin cancer Types _____	

Other condition(s)_____

Signature of patient_____ Date_____