

PLEASE COMPLETE THE FOLLOWING MEDICAL HISTORY FORM

Name _____ Date _____
Age _____ Sex _____ How did you hear about us? _____

Reason for today's visit:

Any prior treatments for this problem?

List any prior cosmetic procedures:
Any complications or problems?

Do you exercise regularly? no yes; What is your regular routine?

PLEASE LIST ALL MEDICATIONS, DOSAGES, & FREQUENCY (Including vitamins, herbs and supplements)

MEDICATION ALLERGIES: NONE List:

Check ALL that apply regarding your overall health and add any other medical problems:

CARDIOVASCULAR:

- normal
- artificial heart valve
- pacemaker
- high blood pressure
- heart attack (when?)
- high cholesterol
- bypass or other surgery
- mitral valve prolapse
- other heart problem

NEUROLOGICAL:

- normal
- stroke
- seizure disorder
- Alzheimer's

RESPIRATORY:

- normal
- emphysema
- asthma

INFECTIONS:

- none
- hepatitis
- HIV or AIDS
- TB (tuberculosis)

GASTROINTESTINAL:

- normal
- stomach ulcer
- colitis
- irritable bowel syndrome

PSYCHIATRIC:

- normal
- depression
- anxiety disorder
- other:

ENDOCRINE:

- normal
- diabetes
- thyroid problem

MUSCULOSKELETAL:

- normal
- arthritis
- artificial joint
- fibromyalgia

BLOOD/LYMPH:

- normal
- enlarged lymph glands
- bleeding problems

SKIN:

- normal
- keloids
- poor/slow healing

HEAD/NECK:

- normal
- hearing aid
- glaucoma
- plastic surgery:

GENERAL:

- normal
- fever
- weight loss

OTHER MEDICAL PROBLEMS: _____

Previous skin cancer: _____

MAJOR ILLNESSES OR HOSPITALIZATIONS: none LIST: _____

FAMILY HISTORY: melanoma other skin cancer (basal cell or squamous cell) bleeding problems

other major medical problems:

Occupation: _____ Marital Status: S M D W

Do you wear: dentures glasses contact lenses

Smoking: no former yes; how many packs/day? _____

Alcohol: no social/occasional drinking only

Alcohol or drug problems/addictions: no describe: _____

BAUCOM & MINA DERM SURGERY, LLC

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PATIENT DEMOGRAPHIC INFORMATION

Date: _____ Updated: _____ Updated: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

County: (circle or write in): Cherokee Cobb Dekalb Fayette Forsyth Fulton Gwinnett Hall Henry
Other: _____

Race/Ethnic Group (circle one): Hispanic Non-Hispanic Other _____ Prefer not to answer

Preferred language (if other than English): _____

Phone# Home: _____

Work: _____

Cell: _____

Date of Birth: _____ Social Security Number: _____

Email Address: _____

Preferred Pharmacy: _____ Phone #: _____

** Emergency Contact: _____

Phone: _____

Relationship to Patient: _____