Dermatology Associates of West Texas, LLP

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PATIENT MEDICAL INFORMATION

Name (last):_____(first)_____(MI)_____Date:_____

List **Allergies to Medications:**_____

List all current Medications (Prescription & OTC): _____

_____

_____

Do you have any current or past diseases/conditions involving the following:

	Yes	No	Specifics		Yes	No	Specifics
Arthritis	☐	☐	_____	HIV	☐	☐	_____
Artificial Joint(s)/Valve	☐	☐	_____	Hysterectomy	☐	☐	_____
Asthma	☐	☐	_____	Kidney	☐	☐	_____
Bleeding Tendency	☐	☐	_____	Liver	☐	☐	_____
Diabetes	☐	☐	_____	Lungs	☐	☐	_____
Glaucoma	☐	☐	_____	Pacemaker/Defibr	☐	☐	_____
Headaches	☐	☐	_____	Seizures	☐	☐	_____
Heart Condition	☐	☐	_____	Thyroid	☐	☐	_____
Hepatitis B	☐	☐	_____	Skin Cancer	☐	☐	
Hepatitis C	☐	☐	_____	Type: _____			
High Blood Pressure	☐	☐	_____	Location: _____			

Other Medical Conditions: _____

Check all that apply:

Are you allergic to: ____ Latex _____Lidocaine _____ Epinephrine _____ Adhesive in Tape _____ Topical Antibiotics

Do you use: _____Tobacco products _____Alcohol _____ Tanning beds/Sun Tanning _____ Illicit Drugs

Sun Exposure: _____ Occupational _____Recreational _____ Other (i.e. gardening)

Sun Protection: _____ Avoidance _____ Protective Clothing _____ Sunscreen _____ None

(Women) Are you pregnant? _____ Nursing?____

Is there a history in your family of: _____ Autoimmune Disorders (ieLupus/Rheumatoid Arthritis) If yes – parent, sibling, grandparent

_____ Eczema If yes - parent, sibling, grandparent _____ Melanoma If yes – parent, sibling, grandparent

_____ Psoriasis If yes – parent, sibling, grandparent _____ Skin Cancer If yes – parent, sibling, grandparent

What skin problems do you have? _____

_____

_____

Patient Signature