Dermatology Associates of West Texas, LLP
2202 Ithaca Ave, Lubbock, TX 79410 --- 806-797-1202

PATIENT MEDICAL INFORMATION

Name (last):______________________(first)________________(MI)_____Date:______

List **Allergies to Medications**:____

List all current Medications (Prescription & OTC): ________________________________

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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? ____

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Patient Signature