

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): _____

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

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