STACIA POOLE, MD, LLC

PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: ____/_____/_____

Address: _____

Please list the phone number you prefer to be called with results/reminders: _____

OK to leave a message? ☐ YES ☐ NO Is this home, cell, work (please circle one)?

Primary Care Physician: _____ Preferred Pharmacy: _____

PRESENT PROBLEM(S):

What is the reason for your visit today? _____

_____.

PAST HISTORY:

Do you now have, or have you ever been diagnosed with any of the following conditions: (Check if yes)

☐ Arthritis	☐ Diabetes	☐ Kidney disease
☐ Asthma	☐ Hearing loss	☐ Leukemia
☐ Atrial Fibrillation	☐ Heart disease/ angina	☐ Lung Cancer
☐ Benign prostate enlargement	☐ Hepatitis B	☐ Lymphoma
☐ Blood Clot	☐ Hepatitis C	☐ Prostate Cancer
☐ Bone Marrow Transplant	☐ High Blood Pressure	☐ Radiation Treatment
☐ Breast Cancer	☐ HIV/AIDS	☐ Seizures
☐ Colon Cancer	☐ High Cholesterol	☐ Staph infection/MRSA
☐ COPD	☐ Hyperthyroid (high)	☐ Stroke
☐ Depression	☐ Hypothyroid (low)	☐ Internal cancer _____

Other medical problems : _____

REVIEW OF SYSTEMS: Do you have or have you had:

		YES	NO	If Yes, please specify
CARDIAC:	Heart pacemaker or defibrillator?			
	Artificial heart valve? History of endocarditis?			
SKELETAL:	Artificial joints?			
SKIN:	Excessive scarring or keloid formation?			
HEME:	Bleeding disorder or excessive bruising?			
IMMUNE:	Problems with immune system? **see below			
	Allergy/sensitivity to adhesive?			
	Rash or allergy to latex / rubber / gloves ?			
	Reaction to local anesthetic? Epinephrine?			
	Problems with topical antibiotic salves?			
	Reaction to iodine?			
ENDOCRINE:	Are you pregnant or nursing?			

(** Ex: transplant, rheumatoid arthritis, Crohn's disease, lupus, chronic prednisone therapy, biologics for psoriasis)

Do you take blood thinners? ☐ NO ☐ YES . ☐ Coumadin ☐ Plavix ☐ Aggrenox ☐ Pradaxa ☐Ticlid ☐ Brillinta ☐ Aspirin ☐NSAIDS ☐ Fish oil ☐ vit E ☐ Effient ☐ Other:_____

MEDICATIONS: Please list (Including over the counter and vitamins/supplements)

_____

_____

DRUG ALLERGIES: ☐ NO ☐ YES Please list: _____

MAJOR SURGERIES: (please list) _____

_____

DERMATOLOGIC HISTORY:

Do you have a personal history of:	Yes	No	Not sure	Please provide details
Melanoma skin cancer				
Basal cell skin cancer				
Squamous cell skin cancer				
Actinic Keratosis (precancer)				
Atypical moles/ dysplastic nevi				
Rosacea				
Psoriasis				
Eczema				

Does anyone in your family (blood relative) have history of the following?	Yes	No	Not sure	If yes, which family member? (ex. mother/father/sibling/child)
Melanoma skin cancer				
Basal cell skin cancer				
Squamous cell skin cancer				
Atypical moles/ dysplastic nevi				
Rosacea				
Psoriasis				
Eczema				

SOCIAL HISTORY: ☐ Employed ☐ Retired ☐ Disabled ☐ Not currently employed outside home

Occupation: (most recent) _____ Hobbies: _____

Do you use sunscreen? ☐ YES ☐ NO ☐ SOMETIMES Ever used a tanning booth? ☐ YES ☐ NO

Alcohol: Do you drink alcohol? ☐ Yes ☐ No If yes, _____ drinks per day or _____ drinks per week .

Tobacco: ☐ Never smoker ☐ Former smoker ☐ Current every day smoker ☐ Current some day smoker

Thank you for your cooperation in providing this information. By doing so, you are helping me to be sure that I have up to date information about your health status and also allowing me to spend more time concentrating my attention on your skin concerns during your appointment.

I authorize Dermatology Service to release medical information to referring physicians

_____ ☐ Reviewed by physician / SP

Patient's signature Today's Date Revised 10/28/16