

Bend Dermatology Clinic, LLC
Personal Medical History

NAME _____ **DATE OF BIRTH** _____

MEDICATION ALLERGIES: _____

NON-MEDICATION ALLERGIES: Latex _____ Others (IVP dye, food dye, etc) _____

DO YOU REGULARLY TAKE ASPIRIN? Yes No

CURRENT MEDICATIONS: _____

MEDICAL HISTORY:(check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Artificial joint | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Malignant melanoma |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Neurological problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Bleeding, excessive | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarring/keloids |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes simplex (cold sores) | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Colon/intestinal disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> HIV disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hives | <input type="checkbox"/> Ulcers |

Other condition(s) describe _____

Women Only: Currently taking birth control pills Currently pregnant

SURGICAL HISTORY (past 2 years) _____

SOCIAL HISTORY: Do you smoke/chew tobacco? Yes No Drink alcohol? Yes No

FAMILY HISTORY: Is there a history in your family of the following diseases?

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Allergies/hayfever | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Malignant Melanoma | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis | |

Other Condition(s) describe _____

Signature of Patient

Date

