PATIENT MEDICAL HISTORY

PATIENT'S NAME: ______________________________

PLEASE SEE ATTACHED SHEET FOR ALLERGIES AND MEDICATIONS

Have you ever been treated for any of the following? (please circle)

Heart disease or pacemaker	yes	no
Prosthetic Heart Valve	yes	no
Stents or Bypass	yes	no
Joint replacement	yes	no
High blood pressure	yes	no
Hepatitis B/C	yes	no
Emotional / Physical Problems	yes	no
Venereal Disease	yes	no

Have you or anyone in your family had any of the following: (please circle and list family member if other than yourself)

Asthma	yes	no	____________________
Autoimmune Disease	yes	no	____________________
Hay Fever	yes	no	____________________
Hives	yes	no	____________________
Eczema	yes	no	____________________
Diabetes	yes	no	____________________
Psoriasis	yes	no	____________________
Skin Cancer	yes	no	____________________
Melanoma	yes	no	____________________

In the last 6 months have you had an accident or operation?

____

____

Have you ever been treated for a skin disorder before?

____

____

Have you ever had a treatment for the skin called grenz ray treatments? Yes No Not Sure

I use sunscreen: always sometimes never

I smoke: always sometimes never

Do you drink? (how much?) ____________________________

____

What soap do you use? ____________________________

____

What moisturizer do you use? ________________________

____

WOMEN:

Are you pregnant or planning a pregnancy?
Yes No

Do you take birth control pills?
Yes No

HIPPA:

In order to ensure your privacy Hampton Dermatology, PC will only discuss your medical records with you, unless written consent is granted to do otherwise.
If you wish to permit other person (s) (I.e. husband, wife, parent, doctor, etc) to discuss your medical condition with us or to have access to your medical records, those person (s) must be listed below.

NOTE: This consent will remain in effect until changed in writing by the patient or guardian.

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________

To the best of my knowledge, the medical information provided is correct.

Signature ______________________________________

Date: ______________________________________