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Patient: ____ Date: _______________

Who is your primary care physician? ____________________________________

Who referred you to Georgia Skin Cancer & Aesthetic Dermatology? _______________________

If self-referred, how did you hear about us?

ÿ Friend ÿ Internet
ÿ Family Member ÿ Newspaper
ÿ Television ÿ Radio
ÿ Other ÿ Yellow Pages

Are you allergic to any medications? ÿ No ÿ Yes **If yes, please list below:**

1. _____________________________________ 3. _____________________________________

2. _____________________________________ 4. _____________________________________

List all medications you are currently taking (including prescriptions, over-the-counter medications, vitamins and herbals):

1. __________________________ 4. __________________________ 7. __________________________

2. __________________________ 5. __________________________ 8. __________________________

3. __________________________ 6. __________________________ 9. __________________________

Are you pregnant (women)? ÿ Yes ÿ No ÿ Trying

Chronic Medical Problems:

1. _____________________________________ 4. _____________________________________

2. _____________________________________ 5. _____________________________________

3. _____________________________________ 6. _____________________________________

List all surgical procedures you have had:

1. __________________________ 3. __________________________

2. _____________________________________ 4. _____________________________________

Do you have now or have you ever had diseases or conditions of (please check Yes or No):

SKIN

Have you ever had skin cancer?	ÿ Yes	ÿ No
Has anyone in your family had skin cancer?	ÿ Yes	ÿ No
Do you have a history of any specific skin disease?	ÿ Yes	ÿ No
Do you have problems with healing?	ÿ Yes	ÿ No
Do you develop keloids or thickened scars after surgery?	ÿ Yes	ÿ No
Do you bleed easily?	ÿ Yes	ÿ No

Do you develop skin rashes in reaction to ÿ Medications ÿ Food ÿ Environment

LUNGS

Bronchitis	ÿ Yes	ÿ No
Emphysema	ÿ Yes	ÿ No
Asthma	ÿ Yes	ÿ No
Shortness of Breath	ÿ Yes	ÿ No
Tuberculosis	ÿ Yes	ÿ No

CARDIOVASCULAR

High Blood Pressure	ÿ Yes	ÿ No
Chest Pain	ÿ Yes	ÿ No
Heart Attack	ÿ Yes	ÿ No
Heart Murmur	ÿ Yes	ÿ No
Irregular Heart beat	ÿ Yes	ÿ No
Stroke	ÿ Yes	ÿ No
Pacemaker	ÿ Yes	ÿ No
Defibrillator	ÿ Yes	ÿ No

ARTHRITIS

Pain in joints	ÿ Yes	ÿ No
Swelling in joints	ÿ Yes	ÿ No
Artificial joint	ÿ Yes	ÿ No

OTHER SYSTEMIC

Diabetes	ÿ Yes	ÿ No
Thyroid Abnormality	ÿ Yes	ÿ No
Kidney/ Bladder Problems	ÿ Yes	ÿ No
Frequency/Burning	ÿ Yes	ÿ No
Hepatitis	ÿ Yes	ÿ No

GASTROINTESTINAL/ANTIBIOTIC USE

Indigestion with antibiotics?	ÿ Yes	ÿ No
Nausea/Vomiting/Diarrhea with Antibiotics?	ÿ Yes	ÿ No

PSYCHIATRIC

Depression	ÿ Yes	ÿ No

NEUROLOGIC

Epilepsy	ÿ Yes	ÿ No
Seizures	ÿ Yes	ÿ No
Fainting	ÿ Yes	ÿ No

SOCIAL HISTORY

Do you drink alcohol?	ÿ Yes	ÿ No	If yes, _________________ drinks/day
Do you use recreational drugs?	ÿ Yes	ÿ No	If yes, what _______________________
Do you smoke?	ÿ Yes	ÿ No	If yes, how much? _________________
Have you had or have you been exposed to HIV (AIDS)?	ÿ Yes	ÿ No	

FAMILY HISTORY

Is there a family history of Asthma?	ÿ Yes	ÿ No	If yes, who? ________________________
Is there a family history of seasonal allergies?	ÿ Yes	ÿ No	If yes, who? ________________________
Is there a family history of hay fever?	ÿ Yes	ÿ No	If yes, who? ________________________
Is there a family history of eczema?	ÿ Yes	ÿ No	If yes, who? ________________________
Is there a family history of skin cancer?	ÿ Yes	ÿ No	If yes, who? ________________________

What is your occupation? ____

Completed by: ÿ Patient ÿ Parent / guardian ÿ Medical Assistant _______(initials)

____ ___________________________

Signature of patient Date

____ ___________________________

Reviewed by Date

Athens u Gainesville u Lake Oconee / Cowles Clinic u 706-543-5858 (Office) 706-543-2050 (Fax)