AFFILIATED DERMATOLOGISTS OF VIRGINIA
MEDICAL HISTORY

Today's Date:	**Patient Name:**
Preferred Pharmacy:	**Date of Birth:**
Location/Phone:	**Chart #:**

Reason for today's visit:_____

Do you currently have or have you ever had:

___Bronchitis	___High Blood Pressure	___Irregular Heartbeat	___Thyroid problems
___Emphysema	___Low Blood Pressure	___Pacemaker	___Kidney Problems
___Asthma	___Chest Pain	___Blood clots/phlebitis	___Bladder Problems
___Chronic Cough	___Heart Attack	___MVP	___Stomach Problems
___Morning Cough	___Heart Murmur	___Diabetes	___Hepatitis (A/B/C)
___Bowel Problems	___Glaucoma	___Arthritis/Joint	___HIV/AIDS

___Cancer (type):_____

Any other?_____ Pregnant? ___Yes ___ No ____n/a

Current prescription medications:_____

_____

_____

Supplements or over the counter medications:_____

_____

Allergies to: ___Latex ____Food ____Medications **Allergy List**:_____

Any surgeries? ___no ___yes List:_____

Have you:	**Do you:**	
___had a blood transfusion	___have an artificial joint	___smoke
___been exposed to HIV/AIDS	___require antibiotics before surgery	___drink alcohol
___had adverse reaction to dental anesthesia	___bleed easily	___use any drugs (other than above)

Have you ever had skin cancer (basal cell, squamous cell, melanoma)? ____yes ___no

If yes, location:_____

Have you ever had a mole biopsy? ___yes ___no Location:_____

Do you have a family history of melanoma? ___yes ___no Relationship:_____

Are you interested in:		**Do you:**		
___ Botox	____ laser treatment	___Use tanning bed	___use sunscreen	___tan easily
___ fillers	____ chemical peels	___ Spray tan/self tan	___burn easily	

Current skin care products:_____

Signed_____ _____

(patient or guardian) /Date **(Provider)/Date**

ADOV/2012/nt