Hecker Dermatology Group, P.A.

MEDICAL HISTORY

Patient Name:____ Date:________________

Reason for today's visit:____
Do you have now, or have you ever had diseases or conditions of: (If YES, Please check box)

Lungs:

Bronchitis   Emphysema   Asthma   Chronic Cough   Morning Cough

Vascular:

High Blood Pressure   Chest Pain   Heart Attack   Heart Murmur   Irregular Heartbeat
Mitral Valve Prolapse   Pacemaker   Blood Clots/Phlebitis

Other Systemic:

Diabetes   Thyroid   Kidney   Bladder   Joint/Muscle/Arthritis
Bowel   Cancer   Stomach   Hepatitis A/B/C

Current Medication: **Y** **N**

Do you have allergies to food or medicine? If yes, Please List_______________________
Do you currently use any prophylactic antibiotics? If yes, Please List_______________________
Do you drink alcohol? If yes, Please List_______Amt per day______
Do you currently use IV Drugs? If yes, Please List_______Amt per day______
Do you currently take any medications? If yes, Please List_______________________
Have you ever been exposed to HIV/AIDS? **Y** **N**
Have you ever had dental anesthesia (Novacaine)? Ever had a blood transfusion?
Are you Latex Intolerant? Any adverse Reaction?

Skin: **Y** **N**

Have you ever had Skin Cancer? If yes, location(s) ______________________________
Family History of Skin Cancer? Relationship: ______________________________
Do you currently use skin care products? If yes, what brand? ______________________________
When exposed to the sun, do you: Tan Tan & Burn Burn
List any other disease or condition we should be aware of: ____
List surgical procedures performed within the last 6 months: ____

Please answer the following questions: **Y** **N**

Do you smoke?
Are you pregnant?
Do you currently use skin care products?
If no, date of last menstrual period:__________________

What is your occupation?___________________________

Y **N**

Do you bleed easily?
Do you have artificial joints, pins or screws?
Do you require antibiotics prior to surgery?

Completed by: Patient: _________________ (Initial)
Nurse: _________________ (Initial)
M.A.: _________________ (Initial)

Signed by: Physician: _________________Date:________
Reviewed by: ______________ Date:________

Pharmacy Location: ____

Preferred Pharmacy: _________________________ Pharmacy Telephone Number:________________________

HECKER DERMATOLOGY GROUP, P.A. WWW.HECKERDERM.COM

3500 NE 5TH AVENUE
POMPANO BEACH, FL 33064
PHONE: (954) 783-2323
FAX: (954) 783-2321

7401 N UNIVERSITY DRIVE, SUITE 203
TAMARAC, FL 33321
PHONE: (954) 783-2323
FAX: (954) 532-5331