BRENTWOOD DERMATOLOGY

Medical Record # _____(office use only)

Patient Name:_____Date of Birth:

Preferred Name: _____

Do you take these medications daily?	Yes	No
Aspirin _____mg		
Advil/ Motrin/ Aleve/ Celebrex? Name:_____ Dose: _____		
Coumadin/Plavix/Xarelto Pradaxa/Warfarin?		
Any non-listed blood thinner? Name: _____		

Medication Allergies: please CIRCLE NKDA if none: **NKDA**

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____

List of ALL current medications: including prescriptions, over the counter, vitamins and supplements, or eye drops:

Name: _____ Dose/Route: _____Frequency/Directions: _____
Name: _____ Dose/Route: _____Frequency/Directions: _____
Name: _____ Dose/Route: _____Frequency/Directions: _____
Name: _____ Dose/Route: _____Frequency/Directions: _____

Medical History: Past or Present	YES	NO	Explain:
Blood or Bleeding Disease			
Heart Disease			
History of Heart Murmur?			
Kidney Disease			
Liver Disease			
Lung Disease			
Thyroid Disease			
Arthritis			
Diabetes			
High Blood Pressure			
Infectious Disease			
Psychological Disease i.e. depression/anxiety			
Ear/Nose/Throat Disease			
Non Skin Cancer			
Immunological Disease			
Skin Disease			
Skin Cancer			
Melanoma			
Eye Disease			
Contact Allergies: Latex/Nickel/Rubber			
Do you have Pacemaker/Defibrillator/ Implant Cardiac Monitor			
Artificial joint or heart valve			
Do you form Keloids? (THICKENED SCARS)			
Do you take antibiotics prior to routine dental procedure?			
Have you ever fainted for local anesthesia?			
Have you ever had rheumatic Fever?			

65 years and older: Have you ever had a Pneumonia Vaccination?			
All Ages: Have you had a Flu shot?			

Social History	**Yes**	**No**	**How Much?**
Do you live alone?			
Do you drink Alcohol? If yes, how many a day?			1 ___ 2___ 3 + ___
Do you use recreational drugs?			
Have you used a tanning bed?			
Do you use ANY type of tobacco products?			
Have you ever Smoked?			

Family Medical History:	**Mother**	**Father**	**Blood Relative**
Acne			
Arthritis			
Asthma			
Non- Skin Cancer			
Eczema			
Diabetes			
Lupus			
Hives			
Melanoma			
Skin Cancer			
Psoriasis			
Hay Fever			

***Females only:**	**Yes**	**No**
Do you take birth control?		
Are you pregnant?		
Are you breast feeding?		
Do you plan on becoming pregnant?		

List Surgeries & Dates (please list ALL):

1. _____ 3. _____ 5. _____

2._____ 4._____ 6. _____

Occupation: _____ Pharmacy Name: _____ Phone: _____

Hobbies: _____ Address/City: _____

Leisure Activities: _____ OTHER Medical Conditions: _____