

Clarkston Dermatology & Vein Center
New Patient Medical History

Patient Name: _____ Birth Date: _____ Today's Date _____

Occupation: _____ Reason for today's visit: _____

How did you learn about our office: _____

Emergency Contact/Relationship: _____ Emergency Contact Phone: _____

Pharmacy Name: _____ Location & Major Cross Streets: _____

Pharmacy Phone: _____ Do you mail away your prescriptions: _____

What is the name of your family physician or pediatrician? _____

Please mark any of the following you have had in the past or currently have:

- | | | |
|---|--|--|
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anxiety / Depression |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Allergies | <input type="checkbox"/> Eye Problems |
| <input type="checkbox"/> Other Heart Disease | <input type="checkbox"/> Other Lung Disease | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Exposure to TB | <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Fainting | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Headache | <input type="checkbox"/> Bleeding/Clotting Disorder |
| <input type="checkbox"/> Diseases of the Colon | <input type="checkbox"/> Stroke | <input type="checkbox"/> Abnormal Skin Healing |
| <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Cosmetic Surgery |
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Reactions to Local Anesthetic |
| <input type="checkbox"/> IV Drug Use | <input type="checkbox"/> Pre-medication requirements | <input type="checkbox"/> Reactions to Substances |
| <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Currently Pregnant or | <input type="checkbox"/> Applied to the Skin |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Breast Feeding | |

Please list any operations and serious illnesses not listed above: _____

Family history of skin cancer? Yes _____ No _____ Type: _____ Relation: _____

Allergies to medications: _____

Current medications: 1. _____ 2. _____ 3. _____

Signature of patient and/or guardian: _____ **Date:** _____

Signature of assistant: _____ Date: _____ Reviewed by: _____