New Patient Medical History Form **Laing Dermatology**

Name_____ DOB_____ Today's Date_____

Occupation_____ Employer_____

Do you have any problems with local anesthetics: YES/ NO describe:_____

Allergies to medication_____

Non Drug allergies_____

List your Medications: _____ _____ _____

_____ _____ _____

_____ _____ _____

SKIN Diseases that YOU have:_____

SKIN Diseases that run in your family (ie. Eczema, psoriasis etc):_____

Other Diseases that YOU have:_____

Have you had or is there a family (blood rel) history of LYMPHOMA or Multiple Sclerosis? YES/NO

Is there a :	**IN YOU**	**IN A BLOOD RELATIVE**	if yes what relative:
History of Skin Cancer-BCC/SCC/other:	YES/NO	YES/NO	_____
History of Melanoma	YES/NO	YES/NO	_____
History of Atypical/dysplastic moles:	YES/NO	YES/NO	_____

Do you have a PACEMAKER: YES/NO
DEFIBRILLATOR: YES/NO
Artificial Heart Valve: YES/NO
Artificial Joint: YES/NO

Do you take blood thinners (circle): PLAVIX, COUMADIN/WARFARIN, ELIQUIS
AGGRENOX, IBUPROFEN/ other NSAID, ASPIRIN, BC/GOODY POWDERS

Do you have or have you ever had HEPATITIS: YES/NO A, B, C, other
Are you HIV+ YES/NO

Do you go to a TANNING BED: routinely, occasionally, in past, never

Do you drink alcohol (beer, wine, liquor): YES/NO #drinks/week_____

Do you Smoke tobacco/cigarettes: YES/NO #packs/day____; QUIT____#years ago

Have you had this season's FLU Shot given between Jan 1- March 31 or Oct 1-Dec 31 YES/NO

Please **circle** any of the following that you currently are affected by:

Constitutional: weight gain, weight loss, fatigue, fever, night sweats
HEENT: sinus trouble, frequent headaches
CV: pacemaker, defibrillator, artificial heart valve, congenital heart defect
Musculoskeletal: rheumatic fever, arthritis
Skin: tendency to hypertrophic scar/keloid, photosensitivity, itching, recurrent skin infections, tanning bed use
Hematologic/lymphatic: Bleeding trouble
Endocrine: excessive sweating, temperature intolerance, increased sebum/increased oil production, PMS
Allergy/Immunology: wound healing problems, immunosuppression
GI: Crohn's, Ulcerative Colitis, Hepatitis A, B ,C or other hepatitis

Female Patients: Are you pregnant YES/NO
Trying to get pregnant YES/NO
Had a tubal or hysterectomy YES/NO
In menopause YES/NO
Breastfeeding YES/NO

Patient Signature_____ Date_____