VANGUARD DERMATOLOGY

# Medical Information

Name _____ Date: _____

Reason for visit _____

Referred by _____

Primary Care Physician / Tel # / Address _____

Pharmacy name and Tel # _____

## Medications

(List all current medications including prescriptions, over-the counter meds, vitamins, and herbal supplements):

1 _____ 2 _____ 3 _____

4 _____ 5 _____ 6 _____

## Medical History

| | | | | | |
|---|---|---|---|---|---|
| Basal Cell Carcinoma | ❑Yes | ❑No | Asthma | ❑Yes | ❑No |
| Squamous Cell Carcinoma | ❑Yes | ❑No | Atopic dermatitis (eczema) | ❑Yes | ❑No |
| Melanoma | ❑Yes | ❑No | Seasonal allergies | ❑Yes | ❑No |

Other: _____

No drug allergies ❑ Allergies (List all medication allergies): _____

Surgical History: _____

Hospitalization: _____

## Family History

| | | | | | |
|---|---|---|---|---|---|
| Basal Cell Carcinoma | ❑Yes | ❑No | Asthma | ❑Yes | ❑No |
| Squamous Cell Carcinoma | ❑Yes | ❑No | Atopic dermatitis (eczema) | ❑Yes | ❑No |
| Melanoma | ❑Yes | ❑No | Seasonal allergies | ❑Yes | ❑No |

Other: _____

## Social History

Occupation: _____

Tobacco: ❑Yes ❑No ❑Occasionally Alcohol: ❑Yes ❑No ❑Occasionally

| | | | | | |
|---|---|---|---|---|---|
| Difficulty swallowing | ❑Yes | ❑No | Wheezing / difficulty breathing | ❑Yes | ❑No |
| Musculoskeletal/joint pain | ❑Yes | ❑No | Fever | ❑Yes | ❑No |
| Lower leg edema/swelling | ❑Yes | ❑No | Chest pain/angina | ❑Yes | ❑No |
| Weight loss | ❑Yes | ❑No | Special diet | ❑Yes | ❑No |
| Stomach pain or heartburn | ❑Yes | ❑No | Currently pregnant | ❑Yes | ❑No |

Signature: _____ Date: _____