FAIRLAWN DERMATOLOGY, LLC
MEDICAL HISTORY FORM

Patient Name: ______________________________ Date of Birth: ________________ Date: ______________

MEDICATION LIST/SUPPLEMENTS/VITAMINS

Medication Name	Reason for medication

ALLERGIES

Medication	Type of Reaction

Latex Yes ___ No ____ Epinephrine Yes ___ No ____ Lidocaine Yes ____ No ____

MEDICAL HISTORY

Mark an X if you have any of the following:

_____	Autoimmune disorders	_____	Heart disease	_____	Hypertension
_____	Bowel disorders	_____	Hepatitis A, B or C	_____	Kidney disease
_____	Chronic stomach issues	_____	History of endocarditis	_____	Liver problems
_____	Diabetes	_____	HIV/AIDS	_____	Mitral valve prolapse

Skin cancer: Type: ______________________ Location ________________ Date: ___________
Type: ______________________ Location ________________ Date: ___________

Internal cancers: Type: ______________________ Location ________________ Date: ___________
Type: ______________________ Location ________________ Date: ___________

List any other medical diagnoses that do not require medication:

____

____

SURGERIES:

Joint replacements:	Yes _____	No ____	What joint and when: ______________________
Valve replacement	Yes _____	No ____	
Dialysis	Yes _____	No ____	
Organ transplant	Yes _____	No ____	
Pacemaker	Yes _____	No ____	
Defibrillator	Yes _____	No ____	

Other Surgeries ____

____

____

FAMILY HISTORY OF SKIN CANCER OR AUTOIMMUNE DISEASES

Family Member	What type
______	______
______	______
______	______

SOCIAL HISTORY

Cigarette/tobacco usage

Never smoked cigarettes	Yes ____	No _____
Occasionally smoke cigarettes	Yes ____	No _____
Smoke cigarettes daily	Yes ____	No _____
If yes, list quantity per day	______________________	
Chew Tobacco	Yes ____	No _____
Smoke cigars	Yes ____	No _____
Former cigarette user	Yes ____	No _____
When did you quit?	______________________	
Smoke e-cigarettes	Yes ____	No _____

Alcohol use

Drink alcohol Yes ____ No _____

If yes, current consumption Rarely __ Occasionally __ Frequently __ Daily ____

Caffeine Use Occasionally __ Frequently __ Cups/day __

Energy Drinks No __ Yes __ Ounces/day __

EXERCISE

How often do you exercise?

_____ Never
_____ Rarely
_____ Sporadically
_____ Regularly
_____ Physically Active

Have you been hospitalized in the last 30 days?	Yes _____	No ______
Have you had a flu shot this year?	Yes _____	No ______
Have you received a pneumonia vaccine?	Yes _____	No ______

Patient Signature: ____ Date: _______________