FAIRLAWN DERMATOLOGY, LLC MEDICAL HISTORY FORM

Patient Name:	Date of Birth:	Date:
MEDICATION LIST Medication name	Reason for medication	
SUPPLEMENTS/VITAMINS		
SUPPLEMENTS/VITAMINS		
		
MEDICATION ALLERGIES		
Medication name		Type of Reaction
Latex □ Yes □ No		
Epinephrine		
Lidocaine □ Yes □ No		
Other allergies		
ATTENDED A TANGETON A		
MEDICAL HISTORY Morels on Y if you have any of the fall		
Mark an X if you have any of the followaters	owing: Heart disease	Hyportongion
Bowel disorders	Hepatitis A, B or C	Hypertension Kidney disease
Chronic stomach issues	History of endocarditis	Liver problems
Diabetes	HIV/AIDS	Mitral valve prolapse
Skin cancer: Type:	Location	Date:
	Location	Date:
Турс	Location	Date.
Internal cancers: Type:	Location	Date:
· · · · · · · · · · · · · · · · · · ·	Location	Date:
	her medical condition not listed above?	Bute
SURGERIES:		
Joint replacements: Yes No	What joint and when:	
Valve replacement Yes No)	
Dialysis Yes No)	
Organ transplant Yes No)	
)	
Defibrillator Yes No)	
Other Surgeries		
Patient Signature:		Date: