RENEW DERMATOLOGY
PATIENT MEDICAL HISTORY

Name: _____ Date: _____
Last First M.I.

Primary Care Physician Name: _____

Pharmacy Name & Address: _____

Reason for today's visit: _____

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list: _____

Are you allergic to latex? ☐ YES ☐ NO

List all medications, vitamins and herbal supplements you are currently taking (if you have a list, please provide):

_____

Do you have now or have you ever had any of the following diseases or conditions:

Lungs	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Vascular	**YES**	**NO**
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heart Beat	☐	☐
Pacemaker	☐	☐
Phlebitis	☐	☐
Mitral Valve Prolapse	☐	☐
Other Systemic	**YES**	**NO**
Diabetes	☐	☐
Thyroid	☐	☐
Other Hormonal Imbalances	☐	☐

Other Systemic	**YES**	**NO**
Kidney	☐	☐
Bladder	☐	☐
Stomach	☐	☐
Bowel	☐	☐
Hepatitis/Yellow Skin	☐	☐
Glaucoma	☐	☐
Arthritis/Joint Deformity	☐	☐
Epilepsy/Seizures	☐	☐
Fainting	☐	☐
Polycystic Ovary Syndrome	☐	☐
Keloid Scars	☐	☐
Herpes Simplex / Cold Sores	☐	☐
Do you have artificial joints	☐	☐
Other	**YES**	**NO**
Are you pregnant or nursing?	☐	☐
Do you bleed easily?	☐	☐
Do you smoke?	☐	☐
Do you use IV drugs?	☐	☐

Have you had or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO
Have you ever had a reaction to dental anesthesia (Novocain)? ☐ YES ☐ NO

List any other disease or condition you have been diagnosed with:

_____

List any surgical procedures you have had in the past:

_____

Please list any previous skin diseases you have been diagnosed with:

_____

Have you ever had skin cancer: ☐ YES ☐ NO
Has anyone in your family had skin cancer? ☐ YES ☐ NO If YES, who/relation? _____

Please sign below to indicate all of the information on this form is accurate and complete.

Patient / Guardian Signature: _____ Date: _____