Dermatology Associates of Georgia

MEDICAL HISTORY

Patient Name : ______________________________ ____________
Last Name First Name Middle Date of Birth

Drug Allergies : (include type of allergy such as rash, etc.) ______________________________

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Current Medications : ______________________________

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Do you use tobacco products? **Yes** ☐ **No** ☐

If yes what kind(pipe, cigarettes, etc.) ______________________________

Do you use alcohol? **Yes** ☐ **No** ☐

Do you have a history of skin cancer? **Yes** ☐ **No** ☐ **Type** ____________

Do you have a family history of melanoma? **Yes** ☐ **No** ☐

Current Medical Problems: ______________________________

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Past Surgeries: ______________________________

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Anything else you want the doctor to know regarding Medical History: ____________________

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The above information is accurate and complete to the best of my knowledge.

Signature ______________________________ **Date** ____________

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