



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.) _____

Current Medications : _____

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: _____

Past Surgeries: _____

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

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

Signature _____ **Date** _____

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