DERMATOLOGY ASSOCIATES of GEORGIA

MEDICAL HISTORY

☐ Decatur	☐ Johns Creek	☐ DeKalb Medical Center	☐ Piedmont	☐ Monroe
1951 Clairmont Road Decatur, GA 30033 404-321-4600 • Fax 404-320-0987	4285 Johns Creek Parkway Suite A Suwanee, GA 30024 770-622-4412 • Fax 770-622-4191	2665 North Decatur Road Suite 650 Decatur, GA 30033 404-508-0566 • Fax 404-508-0567	2061 Peachtree Road NE Suite 400 Atlanta, GA 30309 404-554-0810 • Fax 404-554-0348	201 Michael Etchison Road Monroe, GA 30655 770-267-5877 • Fax 770-207-4944

Please check a box above for the office of today's visit and the Physician, P.A., or NP seeing: _____

Patient Name: _____ _____/_____/_____
Last Name First Name Middle Date of Birth:

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

_____

Current Medications: (Please provide as much detail as possible)

Medication Name	Dosage	Medication Name	Dosage

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

When was your last Full Body Skin Exam? _____

Are you Pregnant? Yes ☐ No ☐

Do you use tobacco products? Yes ☐ No ☐ If yes, since when? _____ **Age Started:**_____ **Age Stopped:** _____

If yes, what kind of tobacco? (Pipe, Cigarettes, Snuff, Vapor, other) _____

How frequently do you smoke or use tobacco? Usage per day? _____

Number of Cigarettes: _____ Number of Packs: _____ Other: _____

Do you use alcohol? Yes ☐ No ☐ If so, what type? _____

Frequency/amount of alcohol consumed daily: Please check what applies to you:

1-2 drinks per week _____; 1+ drinks daily _____; 4 + weekly ____ Other: _____

Current Medical Problems: _____

_____

_____

Past Surgeries and Date: _____

_____

Anything else you want your Physician, Physician Assistant or Nurse Practitioner to know regarding your Medical History: _____

_____

The above information is accurate and complete to the best of my knowledge. Date: _____ / _____/ _____

Patient Signature: _____

If Parent or Guardian, please include name, relationship and signature: _____

_____