



**DERMATOLOGY
ASSOCIATES
of GEORGIA**

MEDICAL HISTORY

Decatur
 1951 Clairmont Road
 Decatur, GA 30033
 404-321-4600 • Fax 404-320-0987

Johns Creek
 4285 Johns Creek Parkway
 Suite A
 Suwanee, GA 30024
 770-622-4412 • Fax 770-622-4191

Emory Decatur Hospital
 2665 North Decatur Road
 Suite 650
 Decatur, GA 30033
 404-508-0566 • Fax 404-508-0567

Piedmont
 2061 Peachtree Road NE
 Suite 400
 Atlanta, GA 30309
 404-554-0810 • Fax 404-554-0348

Monroe
 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: _____
