Alta Dermatology Group
130 S. 63rd Street ~ Suite 114 ~ Mesa, Arizona 85206
480~981~2888

Medical History

Today's Date: _____/_____/_____

Your name: (print) _____ Date of Birth: _____/_____/_____

Current Medications: (include: aspirin, birth control pills, herbs, laxatives, supplements and vitamins) ❑ **None**

Name	Dose	How Often?	Name	Dose	How Often?
1.			2.		
3.			4.		
5.			6.		
7.			8.		
9.			10.		
11.			12.		
13.			14.		

Special Diet: _____

Pharmacy:

Name: _____ Address/Cross Streets/City: _____ Phone: (____) _____

Past or Present Medical Conditions:

❑ anemia	❑ arthritis	❑ asthma	❑ atrial fibrillation	❑ bladder problems
❑ bleeding disorder	❑ blood transfusion	❑ cancer:type?_____	❑ congestive heart failure	❑ dementia
❑ diabetes	❑ eczema	❑ emphysema	❑ eye/ear disorder	❑ fainting spells
❑ hay fever	❑ headaches	❑ heart disease	❑ hepatitis B	❑ hepatitis C
❑ high blood pressure	❑ hives	❑ keloids	❑ liver disorder	❑ lupus
❑ nervous/emotional	❑ other skin disease	❑ poor wound healing	❑ prostate problems	❑ seizures
❑ stomach ulcer	❑ stroke	❑ thyroid disease	❑ tuberculosis	❑ valley fever

Any condition or problem not listed: _____

_____

Women:

❑ vaginal infections	❑ menstrual problems
❑ presently pregnant	❑ last menstrual period:___/_____/_____

Allergies:

❒ Patient has No Known Allergies			❑ OTHER: _____	❑ OTHER:_____	
❒ EPINEPNRINE	❒ LATEX	❒ LIDOCAINE	❒ PENICILLIN	❒ SULFA	❒ TAPE

Previous Surgeries & Year: (last 5 years)

Year:	**Year:**
Year:	**Year:**
Year:	**Year:**

Personal History: (check all that apply)

❑ smoke	❑ never been a smoker	❑ former smoker-How many yrs. ago?
❑ outdoor recreation in sun	❑ drink alcohol	❑ work with chemicals

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Your name: (print) _____Date of Birth: ____/____/_____

Skin Cancer History:

Have you been diagnosed with Melanoma? ❑ **YES** **Location? _____** ❑ **NO**

Have you been diagnosed with Squamous Cell Carcinoma? ❑ **YES** **Location? _____** ❑ **NO**

Have you been diagnosed with Basal Cell Carcinoma? ❑ **YES** **Location? _____** ❑ **NO**

Have you had any precancerous lesions treated in the past? ❑ **YES** **Location? _____** ❑ **NO**

Have you had any blistering sunburns? ❑ **YES** **Location? _____** ❑ **NO**

Family History:

	Mother	Father	Sister	Brother	Daughter	Son
Melanoma						
(A) Alive (D) Deceased? (circle)	A D	A D	A D	A D	A D	A D

Vaccinations & Other:

Have you had the pneumonia vaccination in the last 5 years? ❑ **Yes** **Date? _____** ❑ **No** ❑ **Not sure**

If yes, name of administering physician: _____ Approximate date of injection:_____

Have you had the flu vaccination this season? ❑ **Yes** **Date? _____** ❑ **No** ❑ **Not sure**

If yes, name of administering physician: _____ Approximate date of injection:_____

Have you had the shingles vaccination? ❑ **Yes** **Date? _____** ❑ **No** ❑ **Not sure**

Do you have an advance directive in place? ❑ **Yes** ❑ **No** ❑ **Not sure**

If "YES": ❑ Do Not Resuscitate or ❑ Full Code

Do you have the legal document/card with you today? ❑ **Yes** ❑ **No***

(If you do not have the legal document/card verifying DNR, you will be considered a full code until we receive documentation)

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For Office Use Only:

Reviewed with:

☐Patient ☐Parent ☐Guardian ☐Other_____

Stays_____

Leaves_____

Where_____

Back_____ Reviewed by: _____M.A. (initial)