Messenger Dermatology - Compass

Name: _____ Date: _____

CURRENT MEDICAL HISTORY

List all Medications you are currently taking. Include prescription and over-the-counter medications: _____

_____

_____

List any known reactions, sensitivities or allergies to food, flowers, plants, weeds or rubber: _____

_____

_____

List any medications you may be allergic or sensitive to: _____

Do you use: ☐ Tobacco ☐ Caffeine ☐ Alcohol

If applicable, are you or could you be pregnant?: ☐ Yes ☐ No *Are you at risk for HIV?:* ☐ Yes ☐ No

Do you require prophylactic antibiotics before a surgical procedure?: ☐ Yes ☐ No
(heart murmur or prosthetic joints, etc.)

PAST MEDICAL HISTORY

List any previous skin conditions you have had: _____

_____

Have you ever had a history of allergies, eczema, hayfever, asthma, hives, migraines or nasal polyps?: _____

_____

Have you ever had any of the following? Please circle:

	YES	NO		YES	NO		YES	NO
Anemia	☐	☐	Arthritis	☐	☐	Liver Problems	☐	☐
Bleeding problems	☐	☐	Tuberculosis	☐	☐	Kidney Problems	☐	☐
Blood Clots	☐	☐	Thyroid Problems	☐	☐	Blood Transfusion	☐	☐
Diabetes	☐	☐	Heart Problems	☐	☐	Stomach Ulcers	☐	☐
Glaucoma	☐	☐	Lung Problems	☐	☐	Intestinal Disorders	☐	☐
Nervous/Mental Disorder	☐	☐	High Blood Pressure	☐	☐	Back Problems	☐	☐
Cancer (other than skin)	☐	☐	Hepatitis/Jaundice	☐	☐	Artificial Joints	☐	☐
Artificial Heart/Valves	☐	☐	Pacemaker	☐	☐			

Do you have any other medical problems not listed above?: _____

_____

FAMILY MEDICAL HISTORY

Is there any family history of heart disease, stroke or cancer (including melanoma)?: ☐ Yes ☐ No

If yes, please explain: _____

_____

Please verify information, initial and date below:

Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____

Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____

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