Messenger Dermatology - Compass

Name: ______________________________ Date: ______________

CURRENT MEDICAL HISTORY

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

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

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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: ______________________

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

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

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

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

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FAMILY MEDICAL HISTORY

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

If yes, please explain: ______________________

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Please verify information, initial and date below:

Initials: ________ Date: _______ Initials: ________ Date: _______ Initials: ________ Date: _______

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