

## South Coast Dermatology Patient History

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Cell \_\_\_\_\_  
Work \_\_\_\_\_ Other \_\_\_\_\_

Occupation: \_\_\_\_\_

Can we release any test results to any family members?

No  Yes (Name): \_\_\_\_\_

Primary Physician:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Referring Physician:

Did a physician refer you?  Yes  No

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Present Problem:** What is the reason for your visit? \_\_\_\_\_

Medications: Prescriptions, vitamins, supplements, herbs you take regularly:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications?  Yes  No

(List): \_\_\_\_\_

Do you take blood thinners?  Yes  No

(List): \_\_\_\_\_

Have you taken aspirin or Vitamin E in the past week?  Yes  No

### Medical History/Review of Systems:

Do you have a pacemaker?  Yes  No

Do you have any artificial joints?  Yes  No

Do you have an artificial heart valve?  Yes  No

Do you take any antibiotics before you go to the dentist?  Yes  No

Please explain: \_\_\_\_\_

(over)

