Iberia Dermatology

MEDICAL INFORMATION

For internal use only

Name: ____________________

List any medication allergies: ____________________

Primary Care Doctor: ____________________
Your Pharmacy: ____________________

Do you have a pacemaker? ☐Yes ☐ No
Has your doctor advised you to take antibiotics before procedures? ☐Yes ☐ No
Do you Smoke? ☐Yes ☐ No
Drink Alcohol? ☐Yes ☐ No

Height __________
Weight__________

List your medications:

____

For Females Only: Are you Sexually Active? ☐Yes ☐No
Are you Pregnant or Breast-Feeding? ☐Yes ☐No

Do ***you*** have any of the following conditions? Check all that apply

☐Excessive Sun	☐Heart Valve Disease	☐Stroke	☐Thyroid Disease
☐Skin Cancer	☐Heart Murmur	☐Seizures	☐Kidney Disease
☐Malignant Melanoma	☐Heart Attack	☐Arthritis	☐Lupus
☐Psoriasis	☐Irregular Heart Beat	☐Diabetes	☐Dermatomyositis
☐Large Scars or Keloids	☐Hepatitis	☐Glaucoma	☐Scleroderma
☐Eczema/Atopic Dermatitis	☐Liver Disease	☐Cancer	☐Allergy to latex
☐Asthma	☐Bleeding Problems	☐Mouth ulcers	☐AIDS/HIV
☐Hay Fever (allergic rhinitis)	☐Lung Disease	☐Cold sores/ Fever blisters	
☐Artificial Joints	☐High Blood Pressure	☐Stomach/Bowel Problems	

Do any ***family members*** have these conditions?
Check all that apply

- ☐Skin Cancer
- ☐Malignant Melanoma
- ☐Lupus
- ☐Dermatomyositis
- ☐Eczema/Atopic Dermatitis
- ☐Asthma
- ☐Psoriasis
- ☐Scleroderma
- ☐Hay Fever/Allergic Rhinitis

Daytime phone numbers where we may contact you with laboratory/test results:
1st Phone #:______________ May we leave a message with your health information at *this* number? ☐ no ☐ yes
2nd Phone #:______________ May we leave a message with your health information at *this* number? ☐ no ☐ yes

May we have your permission to: (please check one)
Discuss your condition and release copies of your medical record to another individual? ☐ no ☐ yes
If yes, with whom? ______________________ Relationship______________
______________________ Relationship______________
______________________ Relationship______________

Who should we notify in an emergency? ______________________ Phone______________

Signature:______________________________ **Date:**____/____/______