

# Albuquerque Dermatology Associates

## New Patient Medical History Form

This is a confidential part of your treatment and will be kept in this office. Information included on this form will not be released to anyone without written authorization from you.

Today's date: \_\_\_\_\_ NAME: \_\_\_\_\_  
(Last) (First) (Mi)

Date of Birth: \_\_\_\_\_ BIRTHPLACE: \_\_\_\_\_ Years in NM: \_\_\_\_\_

Is your general health good now? Y N Date of your last physical exam: \_\_\_\_\_

### PERSONAL HISTORY OF ILLNESS (circle all that apply)

Acne	Hypercholesterolemia
Acid Reflux	Hyperlipidemia
AIDS / HIV	Hypertension
Allergies	Hyperthyroidism
Alopecia	Hypothyroidism
Alzheimer's Disease	Impetigo
Anemia	Irritable Bowel Syndrome
Anxiety	Leukemia
Arthritis	Lymphoma
Asthma	Measles
Bleeding Disorders _____	Melanoma
Blood Clots	Migraines
Cancer What type? _____	Non-Hodgkin's Lymphoma
Congestive Heart Failure	Parkinson's Disease
Chronic Obstructive Pulmonary Disease (COPD)	Psoriasis
Crohn's Disease	Scarlet Fever
Cutaneous T-Cell Lymphoma	Seizures
Dental complications? _____	Skin Diseases _____
Depression	Sinus Problems
Diabetes	Sleep Apnea
Diverticulitis	Strep Throat
Eczema	Stroke
Emphysema	Syphilis
Epilepsy	Tuberculosis
GERD	Ulcerative Colitis
Glaucoma	Ulcers Where? _____
Gout	Vertigo
Hayfever	Vitiligo
Headaches	Warts Sites involved? _____
Heart Disease	
Hepatitis Type? _____	
Hives	

Females: Are you currently pregnant? Y N Date of last pregnancy: \_\_\_\_\_

Are you currently under the care of a psychiatrist? Y N If so, who is the doctor? \_\_\_\_\_

**PAST SURGERIES (What kind and date):**

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**PLEASE LIST ALL CURRENT MEDICATIONS (INCLUDING NON-PRESCRIPTION MEDICATIONS)**

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**PLEASE LIST ANY DRUG ALLERGIES**

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**FAMILY HISTORY OF ILLNESSES**

Has anyone in your immediate family ever had?

High Blood Pressure \_\_\_\_\_ Diabetes \_\_\_\_\_ Cancer \_\_\_\_\_ Melanoma \_\_\_\_\_

Nervous disorders \_\_\_\_\_ Asthma \_\_\_\_\_ Eczema \_\_\_\_\_ Psoriasis \_\_\_\_\_

Seizures/epilepsy \_\_\_\_\_ Hayfever \_\_\_\_\_ Skin Cancer \_\_\_\_\_ Scarring Acne \_\_\_\_\_

Other illnesses, please indicate type: \_\_\_\_\_

**INFORMATION ABOUT PRESENT CONDITION**

Have you consulted another doctor about your present condition? Y N If yes, which doctor? \_\_\_\_\_

Are you currently using any medication (s) to treat your present skin condition? Y N

If yes, please list \_\_\_\_\_

How long has this condition been present? \_\_\_\_\_

Where is the condition located? \_\_\_\_\_

Have you tried other treatments in the past for this condition: Y N

If yes, what kinds? \_\_\_\_\_

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