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

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):

_____
_____

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

_____
_____
_____

PLEASE LIST ANY DRUG ALLERGIES

_____

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? _____
_____