DEAN DERM

Patient Medical History

Patient Name : _____ Date: _____

Please list any medical conditions and surgeries that apply to you.

Please list ALL MEDICATIONS you are currently taking (Including aspirin, laxatives, birth control pills, vitamins, etc.)

Drug Name	**Dosage (strength)**	**Frequency taken(ex: daily, as needed)**

Permission to request pharmacy history? Yes No

ALLERGIES (list all known allergies to latex, metals, medications, jewelry, etc.): _____

Do you have a history of skin cancer? Yes No

If so, what type?

Are you pregnant or nursing? Yes No

Do you use tobacco/smokeless tobacco? Yes No

Frequency?

Do you drink alcohol? Yes No

Frequency?

Have you ever used a tanning bed? Yes No

Have you received the flu vaccine this season?

Yes No

****65 and older only****

Have you ever had the Pneumonia vaccine? Yes No

Patient/Guarantor Signature : _____ **Date:** _____

If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.