Stones River Dermatology, PLC
Medical History

Date:_____

Patient's Name:_____ **Date of Birth:**_____

Preferred Name:_____ **Gender: Male Female Other:**

Preferred Phone:_____ **Additional phone:**_____

Pharmacy/Location:_____ **Pharmacy phone:**_____

Referring Provider:_____

Do You Have Any Medication Allergies? None Yes
Please List Known Allergies:_____

Current Medications:_____
_____
_____

Vitamins and Herbal Supplements:_____
_____
_____

Do You Take:

Coumadin? Yes No **Daily Aspirin?** Yes No
Other Blood Thinners: _____

Patient's Past Medical History
Do you currently have (or had in the past) any of the following medical problems?

Skin Cancer ☐ No ☐ Current ☐ Past Type (if known):

Melanoma ☐ No ☐ Current ☐ Past Location and Year:

Arthritis ☐ No ☐ Current ☐ Past Type:

Anxiety ☐ No ☐ Current ☐ Past

Bleeding Disorders ☐ No ☐ Current ☐ Past Type:

Cancer ☐ No ☐ Current ☐ Past Type:

Depression ☐ No ☐ Current ☐ Past

Diabetes ☐ No ☐ Current ☐ Past

Do you take insulin? Yes No

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Eczema ☐ No ☐ Current ☐ Past

Eye Disease ☐ No ☐ Current ☐ Past Type**:**

Heart Disease ☐ No ☐ Current ☐ Past

Patient's Past Medical History (Continued)
Do you currently have (or had in the past) any of the following medical problems?

Hepatitis ☐ No ☐ Current ☐ Past Type**:**

HIV/AIDS ☐ No ☐ Current ☐ Past

Hives ☐ No ☐ Current ☐ Past

Hypertension ☐ No ☐ Current ☐ Past

Kidney Disease ☐ No ☐ Current ☐ Past

Liver Disease ☐ No ☐ Current ☐ Past Type:

Lung Disease ☐ No ☐ Current ☐ Past

Do you have? Asthma COPD Emphysema Other:

Lupus ☐ No ☐ Current ☐ Past

Psoriasis ☐ No ☐ Current ☐ Past

Seasonal Allergies ☐ No ☐ Current ☐ Past

Thyroid Disease ☐ No ☐ Current ☐ Past Type:

Tuberculosis ☐ No ☐ Current ☐ Past

Urinary Infections ☐ No ☐ Current ☐ Past

Weight Loss ☐ No ☐ Current ☐ Past

Was your weight loss? Intentional Unintentional

Other Medical Conditions_____

Patient's Past Surgical History

Please List All Surgeries and Month/Year:

_____

_____

_____

_____

Questions for Women Only

Are you Pregnant? Yes No

Are you breastfeeding? Yes No

Do you take oral birth control pills? Yes No

Other contraceptives? IUD Partner vasectomy Hormonal Implant

Have any family members suffered Breast Cancer? Yes No

Do You Have

Pacemaker: Yes No **Defibrillator:** Yes No **Artificial Heart Valve:** Yes No

Artificial Joint? Yes No **If Yes, Location: _____** **When: _____**

Patient's Family Medical History
Please list any IMMEDIATE FAMILY members with the following medical problems:

☐ Adopted/Unknown

Cancer	☐ Mother	☐ Father	☐ Siblings	☐ Others
Eczema	☐ Mother	☐ Father	☐ Siblings	☐ Others
Hives	☐ Mother	☐ Father	☐ Siblings	☐ Others
Lupus	☐ Mother	☐ Father	☐ Siblings	☐ Others
Melanoma	☐ Mother	☐ Father	☐ Siblings	☐ Others
Skin Cancer	☐ Mother	☐ Father	☐ Siblings	☐ Others
Psoriasis	☐ Mother	☐ Father	☐ Siblings	☐ Others

Are you Married? Yes No Widowed **Do you live alone?** Yes No

Do You Drink Alcohol? Yes No **How many drinks per week:**

Do You Smoke? Yes No

If Yes, how many packs per day?_____

Do you Vape, Juul or use electronic cigarettes? Yes No

Do you dip, chew, or use smokeless tobacco? Yes No

Do you use CBD products? Yes No

Do you regularly outdoor tan or use tanning beds? Yes No

Occupation:_____

Hobbies:_____

Please list any other concerns you wish to discuss with your doctor:

_____

_____

Signature: _____