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	
Eczema	☐ No ☐ Current ☐ Past	
Eye Disease	☐ No ☐ Current ☐ Past	Type:
Heart Disease	☐ No ☐ Current ☐ Past	

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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: ____