SkinMD
BELLE MEADE | NASHVILLE

Medical Record # _____ (office use only)

Patient Name:_____

Date of Birth:_____ Preferred Name: _____

Medication Allergies: please CIRCLE NKDA if none: **NKDA**

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____

List of ALL current medications: including prescriptions, over the counter, vitamins and supplements, or eye drops:

Name: _____ Dose/Route: _____Frequency/Directions: _____

Name: _____ Dose/Route: _____Frequency/Directions: _____

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Do you take these medications daily?	Yes	No
Aspirin _____mg		
Advil/ Motrin/ Aleve/ Celebrex? Name:_____ Dose: _____		
Coumadin/Plavix/Xarelto Pradaxa/Warfarin?		
Any non-listed blood thinner? Name: _____		

Medical History: Past or Present	YES	NO	Explain:
Blood or Bleeding Disease			
Heart Disease			
History of Heart Murmur?			
Kidney Disease			
Liver Disease			
Lung Disease			
Thyroid Disease			
Arthritis			
Diabetes			
High Blood Pressure			
Infectious Disease			
Psychological Disease i.e. depression/anxiety			
Ear/Nose/Throat Disease			
Non Skin Cancer			
Immunological Disease			
Skin Disease			
Skin Cancer			
Melanoma			
Eye Disease			
Contact Allergies: Latex/Nickel/Rubber			
Do you have Pacemaker/Defibrillator/ Implant Cardiac Monitor			
Artificial joint or heart valve			
Do you form Keloids? (THICKENED SCARS)			
Do you take antibiotics prior to routine dental procedure?			
Have you ever fainted for local anesthesia?			
Have you ever had rheumatic Fever?			
65 years and older: Have you ever had a Pneumonia Vaccination?			
All Ages: Have you had a Flu shot?			

Social History	Yes	No	How Much?
Do you live alone?			
Do you use recreational drugs?			
Have you used a tanning bed?			
Do you drink alcohol? If yes, how many a day?			1___ 2___ 3+___
Have you ever smoked?			
Have you had the flu shot?			
Have you had the pneumonia shot?			

Family Medical History:	Mother	Father	Blood Relative
Acne			
Arthritis			
Asthma			
Non- Skin Cancer			
Eczema			
Diabetes			
Lupus			
Hives			
Melanoma			
Skin Cancer			
Psoriasis			
Hay Fever			

***Females only:**	Yes	No
Do you take birth control?		
Are you pregnant?		
Are you breast feeding?		
Do you plan on becoming pregnant?		

List Surgeries & Dates (please list ALL):

1. _____ 3. _____ 5. _____

2._____ 4._____ 6. _____

Occupation: _____ Pharmacy Name: _____ Phone: _____

Hobbies: _____ Address/City: _____

Leisure Activities: _____ OTHER Medical Conditions: _____