COAST DERMATOLOGY & SKIN CANCER CENTER
J. Gregory Neily, DO

Medical History

Date: _____

Reason for today's visit: _____

_____

Review of Systems

Do you have now, or have you ever had diseases or conditions of…(please circle)

Lungs

Bronchitis Emphysema Chronic Cough Morning Cough Asthma

Vascular

High Blood Pressure Chest Pain Heart Attack Heart Murmur Irregular Heartbeat
Pace Maker Blood Clots/Phlebitis Mitral Valve Prolapse

Other Systemic

Diabetes Thyroid Kidney Bladder Stomach Bowel Glaucoma Hepatitis A/B/C Arthritis/Joint
Psychiatric or Nervous Condition

_____

Are you currently on medication? YES NO If yes, please list: _____

_____

Do you have any allergies to food or medicine? YES NO If yes, please list: _____

_____

Do you require antibiotics prior to surgery? YES NO

Do you drink alcohol YES NO If yes, amount per day _____

Have you ever used recreational or IV drugs? YES NO If yes, please list _____

Have you ever been exposed to HIV/AIDS? YES NO

Have you ever had a blood transfusion? YES NO

Have you ever had dental anesthesia (Novocaine)? YES NO

Have you ever had skin cancer? YES NO If yes, location & type _____

Any family history of skin cancer? YES NO Relationship _____

Do you currently use skin care products? YES NO If yes, please list _____

When exposed to the sun, do you… Tan Tan & Burn Burn

List any other disease or conditions we should be aware of _____

_____

Do you smoke? YES NO If yes, how much per day _____

Do you bleed easy? YES NO

Do you have any contagious or infectious condition? YES NO

(Women) Are you pregnant? YES NO If no, date of last menstrual period _____

Do you have artificial joints, pins, or screws? YES NO If yes, location _____

List surgical procedures performed within the last six months _____

_____

Completed by Patient (initial) _____ MA (initial) _____

Signed by Physician: _____