

Dr. Ronald Prussick, M.D., P.C.
The Washington Dermatology Center

MEDICAL HISTORY

Patient Name: _____

Reason for your visit: _____

Are you allergic to any medications? NO YES List: _____

Are you currently taking any medications, over-the-counter drugs, herbal remedies?

NO YES If Yes, List: _____

SKIN CONDITIONS:

When you are exposed to sun, do you: TAN BURN TAN & BURN
Have you ever had skin cancer? NO YES If Yes, Where? _____
Has anyone in your family ever had skin cancer? NO YES If Yes, Who? _____
Do you have a history of any skin problems or diseases? NO YES If Yes, Please List Below: _____

Do you now, or have you ever had, the following diseases or conditions:

Bronchitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Diabetes	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Emphysema	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Thyroid	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Asthma	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Kidney	<input type="checkbox"/> NO	<input type="checkbox"/> YES
High Blood Pressure	<input type="checkbox"/> NO	<input type="checkbox"/> YES	HIV	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Chest Pain	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Stomach	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Heart Attack	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Bowel	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Irregular Heartbeat	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Hepatitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Pacemaker	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Glaucoma	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Phlebitis	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Arthritis/Joint	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Varicose Veins	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Epilepsy/Seizures	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Cold Sores	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Fainting	<input type="checkbox"/> NO	<input type="checkbox"/> YES
Keloids	<input type="checkbox"/> NO	<input type="checkbox"/> YES	Night Sweats	<input type="checkbox"/> NO	<input type="checkbox"/> YES

Generally:

List any other disease or condition: _____

List surgical procedures you have had in the past 5 years: _____

Have you ever had any bad reaction to anesthesia?

	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NEVER HAD ANESTHESIA
Do you smoke?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	
Do you bleed easily?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	
Do you have artificial joints?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	
[Women] Are you pregnant?	<input type="checkbox"/> NO	<input type="checkbox"/> YES	

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2.

Completed by: Patient Parent/Guardian Medical Assistant Initials: _____

Signature: _____ Date: _____

Reviewed by Physician: YES Initials: _____