

**DRS. TAYLOR, WEGENER, KOSTELNIK, BAGINSKI, BURNS & BRAGG**  
**DERMATOLOGY ASSOCIATES**

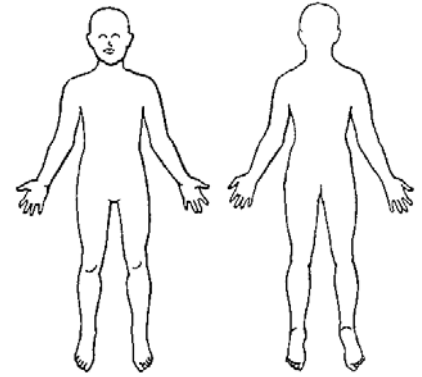
**PATIENT MEDICAL HISTORY**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

1. What problem are you coming in for today?  
*Please describe the problem and indicate what part of the body is affected on the figures to the right.*



*front*

*back*

a. \_\_\_\_\_

b. \_\_\_\_\_

2. How long have you had this problem? \_\_\_\_\_

3. Do you have a family history of:  
\_\_\_ Skin cancer                      \_\_\_ Melanoma  
\_\_\_ Eczema                              \_\_\_ Psoriasis  
\_\_\_ Other \_\_\_\_\_

4. Have you had any other skin-related problems over the past several years?  
\_\_\_\_\_

YES

NO

5. Are you currently using any prescription, or over-the-counter medications for your skin? If yes, what are you using? \_\_\_\_\_  
\_\_\_\_\_

YES

NO

6. Are you currently being treated by another doctor? If yes, for what are you being treated? \_\_\_\_\_  
\_\_\_\_\_

YES

NO

7. Are you allergic to any medications? If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

YES

NO

8. **(FOR WOMEN)** Are you pregnant?

YES

NO

Are you currently taking hormone, or birth control pills?

YES

NO

9. Is there any further information you feel your practitioner should know about your general health? Any surgeries, ulcers, asthma, or other condition?  
\_\_\_\_\_  
\_\_\_\_\_

10. Please list ALL medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Consent for Treatment:** \_\_\_\_\_  
(patient/patient guardian signature)