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Dermatology
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PERSONAL AND FAMILY PAST MEDICAL HISTORY

Patient name: _____ Date: _____

We ask this information for the purpose of providing you with best dermatologic care. Your responses will be held in strict confidence.

It is our recommendation that each new patient have a total body skin exam. This type of exam could save your life if skin problems such as malignant melanoma (black mole skin cancer) are detected.

A total skin exam will require that you remove all clothing other than your underwear and put on a gown.

GENERAL MEDICAL/SURGICAL HISTORY

Please list all medications (prescription and over-the-counter) you take

- | | | |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

Please list all vitamins, herbal medicines or dietary supplements and reason for taking them:

- | | | |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

Please list the names of all your doctors and their specialties:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Do you have allergies? Yes ___ No ___ If yes, list: _____

Are you allergic to any medications? Yes _____ No _____ If yes, circle

- | | | |
|---------------|--------------------------------|--------------|
| Penicillins | Sulfas (Septra, Bactrim) | Erythromycin |
| Tetracyclines | Doxycycline | Codeine |
| Aspirin | Anesthesia (local and general) | Latex gloves |
| Other: _____ | | |

Do you smoke tobacco? Yes No Packs/day: _____ # of years: _____

How much alcohol do you drink? _____

Do you wear sunscreens? _____

Name _____ Date _____

Have you had?

<u>Moles removed</u>	No	Yes
<u>Melanoma skin cancer</u>	No	Yes
<u>Other skin cancer</u>	No	Yes
<u>Keloid or thick scars</u>	No	Yes
<u>Arthritis</u>	No	Yes
<u>Lupus</u>	No	Yes
<u>Autoimmune disorder</u>	No	Yes
<u>Psoriasis</u>	No	Yes
<u>Asthma/eczema/hay fever</u>	No	Yes
<u>Anemia</u>	No	Yes
<u>Blood transfusions</u>	No	Yes
<u>Bleeding disorder</u>	No	Yes
<u>Blood clots</u>	No	Yes
<u>Stroke</u>	No	Yes
<u>High blood pressure</u>	No	Yes
<u>HIV/Aids</u>	No	Yes
<u>Other:</u>		

<u>Cancer</u>	No	Yes
<u>Chemotherapy</u>	No	Yes
<u>Radiation</u>	No	Yes
<u>Breast disease</u>	No	Yes
<u>Headaches</u>	No	Yes
<u>Chest pain/heart attack</u>	No	Yes
<u>Heart murmur</u>	No	Yes
<u>Pacemaker or defibrillator</u>	No	Yes
<u>Artificial joints or valves</u>	No	Yes
<u>Depression/mental illness</u>	No	Yes
<u>Diabetes</u>	No	Yes
<u>Epilepsy</u>	No	Yes
<u>Liver problem/hepatitis</u>	No	Yes
<u>Kidney problem</u>	No	Yes
<u>Lung disease</u>	No	Yes
<u>Tuberculosis/positive PPD</u>	No	Yes
<u>Accutane treatment</u>	No	Yes

Do you take antibiotics before dental or other procedures? (If yes, explain) _____

Females: Are you pregnant or planning to become pregnant in the near future? No Yes

Do any relatives have (if so list who):

1. Melanoma skin cancer: _____
2. Eczema _____

3. Asthma _____
4. Psoriasis: _____

Please put a check next to the procedure/skin problem about which you would like to receive more information:

___ Acne treatments
___ Brown spots
___ Broken capillaries
___ Spider veins
___ Wrinkles
___ Sun damage
___ Facial redness
___ Other: _____

___ Botox
___ Collagen
___ Restylane
___ Chemical peels
___ Laser Facials
___ Laser hair removal
___ Removal of unwanted moles