



cumberland SKIN
surgery and dermatology

Medical Record # _____ (office use only)

Patient Name: _____ Date of Birth: _____
Preferred Name: _____

Medication Allergies: please CIRCLE NKDA if none: NKDA

- _____ Reaction: _____
- _____ Reaction: _____
- _____ Reaction: _____
- _____ 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: _____
 Name: _____ Dose/Route: _____ Frequency/Directions: _____
 Name: _____ Dose/Route: _____ Frequency/Directions: _____

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 drink Alcohol?			
Do you use recreational drugs?			
Have you use a tanning bed?			
Do you use ANY type of tobacco products?			
Have you ever Smoked?			

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):

- _____
- _____
- _____
- _____
- _____
- _____

Occupation: _____

Hobbies: _____

Leisure Activities: _____

Pharmacy Name: _____ Phone: _____

Address/City: _____