

Lower Cape Fear Dermatology Clinic, P.A.
 3904 Oleander Drive Suite 102
 Wilmington, NC 28403
 (910) 452-0400

Name: _____ Date of Birth _____

Primary Physician _____ Send letter? ____Y ____N

If yes, please provide name of office and address _____

Reason for visit _____

Do you have any allergies to medications? ____Y ____N (If yes, list below)

Date	Allergic to:	Allergic symptom

Any history of Melanoma, Basal Cell, Squamous Cell, or Pre-Cancerous Lesions?

_____Yes _____No Explain _____

Do you have a history of any of the following? (check yes or no)

	Y	N		Y	N		Y	N
High Blood Pressure			Diabetes			HIV infection		
Low Blood Pressure			Liver Disease			Artificial Heart Valve		
Heart Arrhythmia			Lung Disease			Bleeding disorder		
Heart Murmur			Kidney Disease			Glaucoma		
Heart Pacemaker			Asthma			Phlebitis (history)		
Congestive Heart Failure			Cancer			Radiation treatments		
Angina			Hepatitis			Hip/Knee replacement		

Any **FAMILY** history of Cancer, Diabetes, or AutoImmune disease? ____Y ____N

Please Explain _____

Do you smoke? _____ If yes, how much _____

Do you drink alcohol? _____ If yes, how much _____

Have you ever been asked to take antibiotics prior to surgical or dental treatment? _____

Have you ever tested positive for TB? _____ Treated? _____

(Women) Are you pregnant? _____ Do you suspect that you are pregnant? _____

Are you nursing? _____

Please list the medications that you are taking on the back of this form (over)

