ADA CSC
Albuquerque Dermatology Associates & Cutaneous Surgery Center, P.A.

MEDICAL HISTORY

This is a confidential part of your treatment and will be kept in this office. Information included on this form will not be released to anyone without written authorization from you.

DATE:_____ **NAME:**_____ **DOB:**_____
(Last) (First) (Mi)

BIRTHPLACE (city & state) _____ **Gender Identity** _____ **Preferred Pronouns**_____

Years in NM:_____ **Occupation:**_____ **Date of last exam/visit with PCP:**_____

Pharmacy/phone #: _____ **PCP/Referring Provider**_____

☐ **NO CHANGES**

AUTOIMMUNE DISEASES/TREATMENT
☐ Hashimoto's Disease _____
☐ Lupus _____
☐ Sjogren's syndrome _____
Other: _____

CARDIAC HISTORY/TREATMENT
☐ Atrial fibrillation _____
☐ CAD (coronary artery disease)_____
☐ CHF (congestive heart failure)_____
☐ Defibrillator _____
☐ Hypertension _____
☐ Hypercholesterolemia _____
☐ Myocardial infarction (heart attack) _____
☐ Pacemaker _____
☐ Other _____

ENDOCRINE/TREATMENT
☐ Diabetes mellitus I II _____
☐ Hyperthyroidism (high)_____
☐ Hypothyroidism (low) _____
☐ Other _____

GASTROENTEROLOGY/TREATMENT
☐ Celiac disease _____
☐ Crohn's disease/ulcerative colitis _____
☐ Diverticulitis _____
☐ GERD (acid reflux)_____
☐ Gout _____
☐ Hepatitis _____
☐ Irritable bowel syndrome _____
☐ Other _____

MUSCULOSKELETAL/TREATMENT
☐ Arthritis _____
☐ Osteoarthritis _____
☐ Osteoporosis _____
☐ Psoriatic arthritis _____
☐ Rheumatoid arthritis_____
☐ Other _____

PSYCHOLOGICAL HISTORY
☐ ADD/ADHD _____
☐ Anxiety _____
☐ Depression _____

PULMONARY/TREATMENT
☐ Asthma _____
☐ COPD/Emphysema_____
☐ Hayfever/seasonal allergies _____
☐ History of tuberculosis_____
☐ Lung cancer _____
☐ Pulmonary embolism _____
☐ Sleep apnea CPAP **Y** **N** _____
☐ Sinus problems/infection _____

SKIN CANCER
☐ Basal cell Carcinoma _____
☐ Melanoma _____
☐ Squamous Cell Carcinoma _____
☐ Other _____

SKIN CONDITIONS/TREATMENT
☐ Acne_____
☐ Actinic Keratosis_____
☐ Alopecia _____
☐ Asteatosis cutis (excessive dry skin) _____
☐ Atypical mole_____
☐ Eczema (atopic dermatitis) _____
☐ History of measles _____
☐ History of Scarlet fever _____
☐ History of varicella zoster/chicken pox/shingles_____
☐ Psoriasis _____
☐ Syphilis_____
☐ Vitiligo _____
☐ Warts_____
☐ Other _____

URINARY/RENAL/TREATMENT
☐ Benign prostatic hyperplasia _____
☐ Dialysis _____
☐ Kidney Disease _____
☐ Prostate cancer_____
☐ Other_____

MISCELLANEOUS/TREATMENT
☐ AIDS/HIV_____
☐ Anemia _____
☐ Breast cancer _____
☐ DVT_____
☐ Leukemia _____
☐ Lymphoma _____
Other: _____

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Are you pregnant or breast feeding? _____ Do you plan on getting pregnant in the near future? _____

Have you had the influenza (flu) vaccination within the past year? **Y** **N**

Have you had the pneumococcal (pneumonia) vaccination within the past five years? **Y** **N**

Have you had the Covid-19 vaccine? **Y** **N**

Do you have a living will? **Y** **N** Do you have a DNR? **Y** **N**

Do you wear sunscreen? **Y** **N** **SPF?** _____ Sun protective clothing? **Y** **N** _____

PAST SURGICAL HISTORY

- ☐ Appendectomy (appendix)
- ☐ Cesarean (c-section)
- ☐ Cholecystectomy (gallbladder)
- ☐ Colostomy
- ☐ Coronary bypass surgery
- ☐ Coronary stent placement
- ☐ Defibrillator
- ☐ Heart Valve Replacement
- ☐ Hip Replacement L R
- ☐ Hysterectomy
- ☐ Knee Replacement L R
- ☐ Lumpectomy L R
- ☐ Mastectomy L R
- ☐ Nephrectomy (kidney removal)
- ☐ Oophorectomy (ovary removal)
- ☐ Pacemaker placement
- ☐ Prostatectomy (prostate removal)
- ☐ Transplant _____
- ☐ Other: _____

PLEASE LIST ALL CURRENT MEDICATIONS (including prescription, over-the-counter and herbal medications)
Please list name, dosage and how the medication is administered.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you require the use of coumadin (warfarin), aspirin, Plavix (clopidogrel), Pradaxa (dabigatran etexilate) or Xarelto (Rivaroxaban)? If yes, please circle.

DRUG ALLERGIES & REACTIONS

☐ **NONE**

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY

☐ Non-smoker ☐ Former smoker ☐ Current smoker how much? _____ ☐ Other _____

Do you drink alcohol? Y N If yes, how many drinks do you have per day? _____< 1 _____ 1 to 2 _____ 3 or more

How many times in the past year have you had 5 or more drinks in a day (men) or 4 or more drinks in a day (women)?_____

FAMILY HISTORY (not the patient)

- ☐ Asthma if so, who? _____
- ☐ Basal Cell Carcinoma/Squamous Cell Carcinoma _____
- ☐ Eczema if so, who?_____
- ☐ Other:_____
- ☐ Hay fever if so, who? _____
- ☐ Melanoma if so, who?_____
- ☐ Psoriasis if so, who? _____