Fiore Dermatology
Patient Medical History

Patient Name:_____**D.O.B:**_____

Patient Primary Care Physician: _____
Name Phone number

Please circle if you have had any of the following:

High Blood Pressure	Cancer	Pacemaker	Hepatitis
Prior Radiation Therapy	Skin Cancer	Glaucoma	Diabetic
Local Anesthetic Allergy	Seizures	Cataracts	Anticoagulants
Heart Disease			

Are you currently Pregnant?: Yes No **Are you currently taking Birth Control?:** Yes No

Please list any past or present medical conditions:

Name	Treatment

Please list any major surgeries:

Name	Date

Please list any drug allergies:

_____

Please list any current medications you are taking:

Name	Dose

Pharmacy Information:_____
Name City Phone number

Patient Signature:_____**Date:**_____