Dr. Jeffrey D. Greiff, MD • Ket Wray, FNP-BC

499 NW 70th Ave. Suite 211, Plantation, FL 33317 • (954) 583-4647 • Fax: (954) 583-8280 • www.floridafamilydermatology.com

MEDICAL HISTORY (Please Fill ALL Areas)

PATIENT NAME: LAST: _____ FIRST:_____ MI_____ DATE_____

PRIMARY CARE DOCTOR: _____ MEDICATION ALLERGIES: _____

OCCUPATION: _____ SOCIAL HISTORY: *(check one)* ☐ SINGLE ☐MARRIED ☐ WIDOWED

HOW DID YOU FIND OUT ABOUT US?_____

WHAT BRINGS YOU IN TODAY? _____

LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING ASPIRIN, OVER THE COUNTER MEDS, VITAMINS AND HERBALS: _____

DO YOU HAVE ANY COSMETIC CONCERNS? _____

DO YOU HAVE NOW, OR EVER HAD, THE FOLLOWING DISEASES OR CONDITIONS *(PLEASE PLACE A CHECK MARK IF APPLICABLE)*

☐ARTHRITIS
☐ARTIFICIAL JOINT
☐ASTHMA
☐BLADDER DISEASE
☐BLOOD CLOTS
☐CANCER
☐CATARACTS/GLAUCOMA
☐EPILEPSY/SEIZURES
☐EMOTIONAL/PSYCHIATRIC
☐FAINTING
☐GASTROINTESTINAL DISORDER
☐HEARING LOSS
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HERPES BREAKOUT
☐HIGH BLOOD PRESSURE
☐HIGH CHOLESTEROL
☐HIV POSITIVE / HIV EXPOSURE
☐IRREGULAR HEARTBEAT
☐KIDNEY DISEASE
☐LIVER-GALLBLADDER DISEASE
☐MITRAL VALVE PROLAPSE
☐PACEMAKER
☐POLYCISTIC OVARIES
☐THYROID DISEASE
☐TUBERCULOSIS / LUNG DISEASE
☐VENEREAL DISEASE

LIST ANY OTHER DISEASES AND CONDITIONS NOT LISTED ABOVE: _____

_____

LIST ANY SURGICAL PROCEDURES YOU HAVE HAD: _____

_____

HAVE YOU EVER HAD SKIN CANCER? ☐YES ☐ NO IF YES, PLEASE SPECIFY WHAT KIND AND BODY LOCATIONS:

_____

DO YOU DEVELOP SKIN RASHES IN REACTION TO ANY MEDICATIONS, FOOD, OR THE ENVIRONMENT? IF YES PLEASE SPECIFY: _____

DO YOU DRINK ALCOHOL? ☐YES ☐ NO IF YES, PLEASE SPECIFY _____

DO YOU USE RECREATIONAL DRUGS? ☐YES ☐ NO IF YES, PLEASE SPECIFY _____

DO YOU SMOKE? ☐YES ☐ NO IF YES, PLEASE SPECIFY _____

DO YOU HAVE A FAMILY HISTORY OF ECZEMA, LUPUS, RHEUMATOID ARTHRITIS, AUTOIMMUNE DISEASE, THYROID DISEASE, PSORIASIS, OR SKIN CANCER?_____

MENSTRUAL CYCLE: REGULAR / IRREGULAR

ARE YOU PREGNANT OR PLANNING A PREGNANCY? ☐YES ☐