Dr. Edward H. Stolar
Dr. Todd E. Perkins

"Excellence in Dermatology Care"

MEDICAL History Update

YOUR NAME: _____ Todty' s Date: _____

Physician' s Name:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Phone #: _____ When was yo ur last vis it to your physician?

When was your last complete physical"

Please tell us if you have had any of the following by checking the appropriate box:

- D Bacterial Endoc arditis
- D Heart Murmur
- D Irregular Heart Beat
- D High Blood Pressure
- D Low Blood Pressure
- D Rheumatic Heart Fever
- D Rheumatic Heart Disease
- D Artifici al Heart Valves
- D Congenital Heart Lesion
- D Mitra! Valve Prolapse
- D Heart Attack year
- D Angina/ Chest Pain
- D Heart Pacemaker
- D Heart Surgery
- D Congestiv e Heart Failure
- D Hemophilia
- D Blood Dise ase
- D Sickle Cell Anemia
- D Anemia / Bio od Problems
- D Excessive Bleeding
- D Asthma
- D Respiratory Dis eas e
- D Shortness of Breath
- D Hay Fever
- D Sinus Proble ms
- D Tuberculosis
- D Eye Disorders / Glaucoma
- D AIDS
- D Immunosuppressive Disorder s / ARC
- D Any Artificial Replacemen t Artificial Knee Hip, Joint, Pins. Plate
- D Rheumatism Arthritis
- D Neurological Problems
- D Epilepsy / Seizures
- D Psychiatric Problem s
- D Emotio nal Problems
- D Alcoholism
- D Chemical Dependency
- D Drug Addiction
- D Malignancies
- D Cancers, Tumors, Growth s
- D Radiation Treatments
- D Diabetes
- D Kidney Problems
- D Dialysis
- D Liver Problems
- D Hepatit is
- D Stroke
- D Thyroid Problems
- D U lce r Colitis
- D Venereal Disease
- D Herpes
- D Fever Blisters
- D Pregnant months
- D Oral Contraceptives

Please list any ALLERGIES to Drugs, Medications or Anesthetics: _____

Please list any other M EDIC A L CONDIT!ONS not mentioned above: _____

Please list all DRUGS / MED ICATIONS that you cu rrent lyy take: _____

_____ _____

Patient Signature Date