EAST TENNESSEE
DERMATOLOGY
GROUP

R. Paul Unkefer, M.D.

PATIENT HISTORY FORM

Patient Name: ______ MR#: ______

Home Phone ______ Pharmacy ______ Sex ☐ Male ☐ Female

Work Phone ______ Pharmacy Phone ______ Date of Birth ______

Referring Physician ______ Phone Number ______

Referring Address ______

Allergies to Medications: ☐ None 1. ______ Reaction ______

Current Medications: ☐ None 1. ______ 4. ______

2. ______ 5. ______

3. ______ 6. ______

	Yes	No
Aspirin/Motrin/Advil	☐	☐
Coumadin	☐	☐
Birth Control Pills	☐	☐
Are you breast feeding	☐	☐
Are you pregnant	☐	☐
Plan on becoming pregnant	☐	☐

Review of Systems Screen (Current or past problems with)

	Yes	No
Blood/Bleeding Disorders	☐	☐
Heart Disease	☐	☐
Kidney Disease	☐	☐
Liver Disease or Hepatitis	☐	☐
Lung Disease	☐	☐
Thyroid Disease	☐	☐
Arthritis	☐	☐
Diabetes (sugar)	☐	☐
High Blood Pressure	☐	☐
Infectious Disease (TB, HIV)	☐	☐
Received Blood Transfusions	☐	☐
Psychological Disorders	☐	☐
Cancer (non-skin)	☐	☐
Immunologic Disease	☐	☐
Latex/Rubber/Nickel/Food	☐	☐
Skin Disease	☐	☐
Skin Cancer	☐	☐
Melanoma	☐	☐

Do you

	Yes	No
Have a pacemaker or defibrilator	☐	☐
Take antibiotics prior to surgical procedures	☐	☐
Have an artificial joint or heart valve	☐	☐
Form Keloids?	☐	☐

List surgeries:

1. ______ 3. ______ 5. ______

2. ______ 4. ______ 6. ______

Family History (Check the following medical conditions which have occurred in your family:)

Disease	Mother	Father	Blood Relative	None
Acne	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐
Hives	☐	☐	☐	☐
Lupus	☐	☐	☐	☐
Melanoma	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐
Skin Cancer	☐	☐	☐	☐

Social History

	Yes	No	
Do you live alone?	☐	☐	
Do you drink alcohol	☐	☐	Frequency ______
Do you use recreational drugs?	☐	☐	Frequency ______

Occupation ______ Hobbies/ Leisure activity ______

Patient Signature: ______ Date: ______

Reviewed by: ______ Date: ______