



Dermatology Associates of Georgia, L.L.C

PATIENT MEDICAL HISTORY

Patient Name _____
Last Name First Name Middle Initial Birth Date

Decatur Office
1951 Clairmont Road
Decatur, GA 30033
Phone: (404) 321-4600
Fax: (404) 320-0987

Johns Creek
4285 Johns Creek Parkway
Suite A
Suwanee, GA 30024
Phone: (770) 622-4412
Fax: (770) 622-4191

Monroe Office
201 Michael Etchinson Rd.
Monroe, GA 30655
Phone: (770) 267-5877
Fax: (770) 207-4944

Peachtree Corners Professional Center
5635 Peachtree Parkway
Suite 270
Norcross, GA 30092
Phone: (678) 728-1500
Fax: (678) 728-1519

Drug Allergies

Current Medications

DO YOU USE TOBACCO PRODUCTS?

Yes No

DO YOU USE ALCOHOL?

Yes No

DO YOU HAVE A HISTORY OF SKIN CANCER?

Yes No

IF YES, THEN WHAT TYPE(S) Basal Cell Squamos Cell Melanoma

SKIN CANCER LOCATIONS _____

DO YOU HAVE FAMILY HISTORY OF MELANOMA?

Yes No

DO YOU HAVE ANY CURRENT MEDICAL PROBLEMS?

Yes No

Past Surgeries

Current Medical Problems

Anything else you want your doctor to know regarding your medical history

By signing below, I acknowledge that the above listed medical information is accurate and complete to the best of my knowledge.

Patient Signature

Date Signed