



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

Dekalb Medical Office

2665 N. Decatur Road
Suite 650
Decatur, GA 30033
Phone: (404) 508-0566
Fax: (404) 508-0567

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

Squamous 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