Fanny J. Berg, M.D., P.A.

Today's Date:____________________

Patient Name ____Age________Date of Birth____________________
First Middle Initial Last

MEDICAL SUMMARY

Reason for visit with Dr. Berg:____

Do you have a history of any specific skin disease or skin disorder? If yes, describe: ____
____

Do you have a family history of skin disease or allergy? If yes, describe: ____
____

Have you ever had skin cancer? Yes No
Has anyone in your family ever had skin cancer? Yes No
Do you have problems healing? Yes No
Do you develop keloids (scars) after surgery? Yes No
Do you bleed easily? Yes No
Have you ever had Novocaine (dental anesthesia)? Yes No If yes, any adverse reaction?__________________________________
Do you have/have you been exposed to HIV/AIDS? Yes No
Medication Allergies (incl. penicillin, sulfa, aspirin, codeine, etc.):____

Do You Develop Skin Rashes in Reaction to:

Medications Yes No	Food: Yes No	Environment: Yes No
Bandages: Yes No	Topical Neosporin: Yes No	Other:

Please List All Prescription and Over-the-Counter Medications You Are Taking

Medication	Dose	How Often is Medication Taken	Reason for Taking Medication

PERSONAL MEDICAL HISTORY

Do You Have Now or Have You Ever Had:

Bronchitis YES NO	Irregular Heartbeat YES NO	Urinary Frequency/Burning YES NO
Emphysema YES NO	Phlebitis/Inflammation of Veins YES NO	Stomach Absorptive Disorder YES NO
Asthma YES NO	Blood Clots YES NO	Nausea, Vomiting, Diarrhea When Taking Antibiotics YES NO
Chronic Cough YES NO	Pacemaker/Defibrillator YES NO	Yeast Infection When Taking Antibiotics YES NO
Morning Cough YES NO	Connective Tissue Disease YES NO	Arthritis/Joint Deformity YES NO
Shortness of Breath YES NO	Jaundice, Hepatitis, Cirrhosis YES NO	Arthralgia YES NO
Wheezing YES NO	Anemia YES NO	Artificial Joint YES NO
High Blood Pressure YES NO	Diabetes YES NO	Limited Motion YES NO
Chest Pain YES NO	Excessive Thirst/Hunger YES NO	Convulsions, Epilepsy, Seizures YES NO
Heart Attack YES NO	Amputation YES NO	Fainting YES NO
Heart Murmur YES NO	Thyroid Disease YES NO	Psychiatric Illness YES NO
	Dialysis YES NO	Other:

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SOCIAL HISTORY

Patient Name: ________________________________

****PLEASE COMPLETE ALL SECTIONS BELOW****

ETHNICITY: (circle one)	**RACE**: (circle one)	**PREFERRED LANGUAGE**: (circle one)
Are you Hispanic? Yes No	Caucasian African American Asian Native American Hispanic Pacific Islander Other:______________________	English Spanish Other:___________________
TOBACCO USE Current Past Never	**ALCOHOL USE** Yes No	**STREET DRUG USE** Yes No
Packs per day	How Often	How Often
How many years	Amount	Amount
	Type	Type
Are you Pregnant? Yes No	Occupation:	Hobbies:
Marital Status: Married Single Partnered Divorced Widowed	Spouse's/Partner's Name:	Number of Children:

PHARMACY – please provide your Pharmacy Name and Location:

PROCEDURES/SURGERIES – please provide Type of Procedure/Surgery and Date of Procedure/Surgery: