Bonita Dermatology, PA
9411 Fountain Medical Ct., St. 100
Bonita Springs, FL 34135
Dermatology Medical History

Name: ___________________________ D.O.B: _____/_____/_____ Today's Date: _____/_____/_____

Are you allergic to any medications? _____ Yes ______ No

If yes, please list: ____

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1. ____________________________________ 7. _____________________________________
2. ____________________________________ 8. _____________________________________
3. ____________________________________ 9. _____________________________________
4. ____________________________________ 10. _____________________________________
5. ____________________________________ 11. _____________________________________
6. ____________________________________ 12. _____________________________________

Do you have now, or have you ever had diseases or conditions of: (Please check Yes or No)

Pulmonary	Yes	No	Other Systemic:	Yes	No
Bronchitis	___	___	Diabetes	___	___
Emphysema	___	___	Excessive thirst / hunger	___	___
Asthma	___	___	Amputation	___	___
Chronic Cough	___	___	Thyroid	___	___
Morning Cough	___	___	Kidneys	___	___
Shortness of Breath	___	___	Dialysis	___	___
Wheezing	___	___	Bladder	___	___
			Frequency / burning	___	___
Cardiovascular			Gastrointestinal	___	___
High Blood Pressure	___	___	Celiac	___	___
Chest Pain	___	___	Nausea, vomiting, diarrhea		
Heart Attack	___	___	or yeast infections when		
Irregular Heartbeat	___	___	taking antibiotics	___	___
Phlebitis	___	___	Arthritis / Joint Deformity	___	___
Blood Clots	___	___	Artificial Joint	___	___
Pacemaker	___	___	Prophylactic Antibiotics	___	___
Defibrillator	___	___	Epilepsy or Seizures	___	___

List any other diseases or conditions: ____

List surgical procedures and/or hospitalizations you have had in the last 6 months:

____

________________________________ _____ / _____ / _____
Patient or Guardian Signature Today's Date