GENERAL MEDICAL HISTORY
TANYA KORMEILI, M.D.

NAME____**DATE**_____________________

REASON FOR TODAY'S VISIT____

- **Are you allergic to any medications**? ◻ Yes ◻ No

  If yes, please list ____

- **Have you ever had an adverse reaction to dental anesthesia (Novocaine**)? ◻ Yes ◻ No

- **Please list all current medications**____

  ____

- **Please circle any blood thinners you are currently taking**:

Aspirin **Motrin** **Advil** **Ibuprofen** **Coumadin** **Vitamin E** **Echinacea** **Garlic**

Do you have or have you ever had diseases or conditions of:

CARDIOVASCULAR	**YES**	**NO**
High Blood Pressure		
Heart Attack/Angina		
Heart Murmur		
Pacemaker		
Mitral Valve Prolapse		
Artificial Valves		
Stroke		

PULMONARY/LUNGS	**YES**	**NO**
Asthma		
Tuberculosis		
Shortness of breath		
Chronic cough		

AUTOIMMUNE	**YES**	**NO**
Systemic Lupus		
Rheumatoid Arthritis		
HIV/AIDS		

OTHER SYSTEMS	**YES**	**NO**
Diabetes		
Thyroid Disease		
Urinary Disease		
Stomach Ulcers		
Dialysis		
Migraines		
Arthritis		
Seizures		
Depression		
Yeast infections when taking oral antibiotics		
Fainting		
Cancer: Type______________________________		

Please list other medical conditions____

Please list major surgeries____

Are you currently pregnant or nursing?	Yes	No	Explain: ______________________________
Have you ever had skin cancer?	Yes	No	Explain: ______________________________
Is there a family history of melanoma?	Yes	No	Explain: ______________________________
Do you have a history of any skin diseases?	Yes	No	Explain: ______________________________
Do you keloid or scar easily?	Yes	No	Explain: ______________________________
Do you drink alcohol?	Yes	No	If yes, how many drinks per week?____________
Do you smoke?	Yes	No	If yes, how many packs per day?_____________

GENERAL MEDICAL HISTORY (continued)
TANYA KORMEILI, M.D.

Your signature below is an attestation that the above information is true and accurate. It is your responsibility to alert the physician and his/her staff to any changes in your health.

Signature of Patient or Representative____**Date**________

CONSENT TO MINOR PROCEDURES

I hereby give my consent for medical examination and treatment. I consent to routine dermatologic procedures such as skin biopsy, treatment with liquid nitrogen or the removal of minor skin lesions. Risks of such procedures include scarring, infection, recurrence of the lesion and the need for multiple treatments. These procedures will be explained in detail before treatment, and I will be given the opportunity to ask further questions.

Signature of Patient or Representative____**Date**________

PATHOLOGY AND LABORATORY BUILDING

Skin biopsies and other laboratory specimens are sent to the appropriate facility that your insurance specifies. You will be billed separately by these entities. Their fee schedules, billing policies and practices are independent of our office. Inquiries regarding your bill should be directed to those appropriate offices.

REV 11/08