Integrated Dermatology of Mission Viejo, APMC
26691 Plaza, Ste 230, Mission Viejo, CA 92691-6300
Tel 949-364-2904
Fax 949-364-2909

Medical Information

Name: _____ **DOB:** _____
Last, First Middle or Initial *mm/dd/yyyy*

Medical History: *Please check all that apply*

❑ Seizure	❑ Heart Attack	❑ Crohn's	❑ Diabetes	❑ Multiple Sclerosis	Other(s) Please specify:
❑ Stroke	❑ Hypertension	❑ Ulcerative Colitis	❑ Pancreatitis	❑ Scleroderma	
❑ Asthma	❑ Pacemaker	❑ Acid Reflux	❑ Arthritis	❑ HIV	_____
❑ COPD	❑ Hepatitis	❑ Kidney Disease	❑ Anemia	❑ Skin Cancer	
❑ Emphysema	❑ Gallstones	❑ Thyroid disease	❑ Lupus	❑ Transplant	_____

Surgical History: *Please list surgeries done especially joint*

_____ _____ _____

_____ _____ _____

Allergies: *Please list medication allergies and respective reactions*

Medication	Reaction	Medication	Reaction

Medications: *Please list current medication(s) or state NONE.*

Name	Dose	How often	Name	Dose	How often

Immunization History:

Have you had COVID-19 Vaccine? (Circle one) Yes No If so, how many doses? _____

Pharmacy Information: *Please provide preferred pharmacy information*

Name: _____ ID#: _____

Address: _____

City: _____ State: _____

Tel: _____ Fax: _____

By signing below, I acknowledge that under the penalty of law all information provided above are true and correct to the best of my knowledge.

Patient Signature _____ Date _____
or Guardian/Legal representative for patient *yyyy/mm/dd*