Westford Dermatology & Cosmetic Center
506 Groton Road
Westford, MA 01886

Medical History Questionnaire

Name_____ D.O.B._____

Please list your current medications:

_____
_____
_____

Please list any allergies to medications:

_____
_____
_____

Are you allergic to: adhesives, lidocaine, epinephrine, antibiotic creams or ointments?_____
(**If yes, please circle**)

Please list any medical conditions you currently have:

_____
_____
_____

Please list any previous or current surgical procedures you have had:

_____
_____
_____

Have you ever had skin cancer (**if yes** please provide location and type)_____
_____
_____

Do you have a family history of skin cancer (if so, who had it and what type)_____
_____
_____
_____

Name of Pharmacy_____**Address**_____**Phone #**_____

Primary Care Physican_____
Name **Address** **Phone #**

***** What Provider referred you here today? Dr. / NP /PA** _____