Florida Medical Clinic Dermatology
Your life. Our specialty.

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Date:_____

Patient Name: _____ D.O.B:_____ Sex: ☐ M ☐ F
Address: _____City:_____State:___ Zip:_____
Cell#:_____ Home#:_____Referred by:_____
Height: _____ Weight: _____ Reason for today's visit:_____
Allergies to medications and/or food:_____
Current Medications/Dosages: _____

PAST MEDICAL HISTORY: Check all that apply and if yes, please explain.

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ Benign Prostatic Hyperplasia
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Prostate cancer
- ☐ Radiation treatment
- ☐ Seizures
- ☐ Stroke

List any other medical conditions/explain:
_____
_____
_____

PAST SURGERIES: Check all that apply and if yes, please explain.

- ☐ Appendix
- ☐ Bladder
- ☐ Mastectomy
- ☐ Lumpectomy
- ☐ Breast Implants
- ☐ Colon Cancer
- ☐ Inflammatory Bowel Disease
- ☐ Diverticulitis
- ☐ Coronary Artery Bypass
- ☐ Heart Transplant
- ☐ Knee Replacement
- ☐ Hip Replacement
- ☐ Kidney Biopsy
- ☐ Nephrectomy
- ☐ Kidney Stone
- ☐ Kidney Transplant
- ☐ Endometriosis
- ☐ Ovarian Cyst
- ☐ Prostate Cancer
- ☐ Prostate Biopsy
- ☐ Skin Biopsy
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Melanoma
- ☐ Spleen - Splenectomy
- ☐ Testicles - Orchiectomy
- ☐ Uterus - Hysterectomy

List any other surgeries/explain: _____
_____
_____

SKIN DISEASE HISTORY: Check all that apply

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Basal Cell Skin Cancer
- ☐ Squamous Cell Skin Cancer
- ☐ Malignant Melanoma

Other:_____
_____

REVIEW OF SYSTEMS: Check all that apply

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Allergy to latex
- ☐ Allergy to epinephrine
- ☐ Artificial heart valve
- ☐ Artificial joints within past two yrs
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ Hepatitis C
- ☐ MRSA
- ☐ Pacemaker
- ☐ Premedication prior to procedure
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnancy or planning a pregnancy

SKIN HISTORY:

How many hours of sun exposure do you get on a daily basis? _____

With sun exposure, do you: □ Burn easily □ Burn sometimes, tan easily □ Tan easily, never burn

How would you describe your PAST sun exposure? □ Heavy □ Moderate □ Light

How would you describe your PRESENT sun exposure? □ Heavy □ Moderate □ Light

What sun-protection do you use? □ Sunscreens □ Hat □ Protective clothing □ None

Do you wear sunscreen? □ Yes □ No If yes, what SPF? _____ Do you tan in a tanning salon? □ Yes □ No

Do you have a family history of Melanoma? Yes □ No □ If yes, which relative? _____

SOCIAL HISTORY:

Do you partake in any outdoor activities (golf, tennis, fishing, gardening, etc.)?

If yes, which one(s):_____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Do you currently smoke? □ Yes □ No If yes, how much per day? _____ Have you ever smoked? □ Yes

Do you drink alcohol? □ Yes □ No If yes, how much per day?_____

Caffeine use? □ Yes □ No If yes, how much per day? _____

PERSONAL HISTORY & HEALTH ASSESSMENT: Check all that apply.

HEMATOLOGIC
□ Problems with bleeding

INTEGUMENTARY (Skin)
□ Problems with healing
□ Problems with scarring (hypertrophic or keloid)

ALLERGIC/IMMUNOLOGIC
□ Immunosuppression
□ Hay fever

CARDIOVASCULAR
□ Chest pain

CONSTITUTIONAL/SYMPTOM
□ Fever or chills
□ Night sweats
□ Unintentional weight loss

ENDOCRINE
□ Thyroid problems

EAR, NOSE, MOUTH & THROAT
□ Sore throat

EYES
□ Blurry Vision

GASTROINTESTINAL
□ Abdominal pain
□ Bloody stool
□ Bloody urine

MUSULOSKELETAL
□ Joint aches
□ Muscle weakness
□ Neck stiffness

NEUROLOGICAL
□ Headaches
□ Seizures

RESPIRATORY
□ Cough
□ Shortness of breath
□ Wheezing

PSYCHIATRIC
□ Anxiety
□ Depression

_____ _____ _____

PATIENT/GUARDIAN SIGNATURE SIGNED/REVIEWED BY PHYSICIAN/PA-C DATE