Name:

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Dermatology

Name: ____ **Date of Birth:** ______ /______ /______

(Last, First, Middle Initial)

Primary Physician: _____________________________ **Pharmacy of Choice**: ______________________________

What is the reason for your visit today?

Concerns: **Location:** **Duration:** **Prior Treatments:**

1. ____
2. ____
3. ____

Past Medical History:

Do you have a history of the following?

Condition		
Adhesive tape allergy	Yes	No
Latex allergy	Yes	No
Local anesthetics allergy	Yes	No
Epinephrine sensitivity	Yes	No
Bacitracin allergy	Yes	No
Neosporin allergy	Yes	No
Anticoagulants / Taking blood thinners	Yes	No
Bleeding disorders	Yes	No
Artificial joint	Yes	No
Artificial heart valves	Yes	No
Congenital heart defect	Yes	No
Pacemaker/defibrillator	Yes	No
Mitral valve prolapse	Yes	No
Immunosuppressed	Yes	No
Organ Transplant	Yes	No
CLL Chronic leukemia	Yes	No
Pre-Op/Pre-dental antibiotics	Yes	No
Memory problems	Yes	No
Fainting / syncope	Yes	No
Hepatitis	Yes	No
HIV positive	Yes	No
MRSA	Yes	No

Condition		
Eczema	Yes	No
Asthma	Yes	No
Hay fever	Yes	No
Heart disease	Yes	No
Diabetes	Yes	No
Kidney disease	Yes	No
Thyroid disease	Yes	No
Lupus	Yes	No
Arthritis	Yes	No
Psoriasis	Yes	No
Cancer (internal)	Yes	No
Blood clots	Yes	No

If yes to the above, please elaborate below:

Do you have a history of melanoma? Yes No
Do you have a history of other skin cancer(s)? Yes No
Details:
____

Current Medications, including over-the-counter _____ If none, check here

Please list medications below:

____
____
____

Allergies to Medications (list medications and type of reaction):

____
____

Name:

Surgical History:

____
____
____

Family History

Do you have a family history of melanoma? Yes No
Do you have a family history of other skin cancer(s)? Yes No
Type(s): ____
Do you have a family history of atopic dermatitis/eczema? Yes No
Do you have a family history of psoriasis? Yes No

Social History:

Occupation: ____
Hobbies: ____

Do you use Tobacco?	No	Yes	Previous	Type: ____________________	
Alcohol Consumption:	None		Socially	Moderate	Daily
Do you use sunscreen?	None		Daily	Occasionally	
Tanning bed use?	None		Current	Previous	

Do you have any other medical problems/conditions that are not listed and that we should be aware of?

____
____
____

Do you currently have or recently have had any of the following symptoms?

Fever/Chills	Yes	No
Nausea/vomiting	Yes	No
Unexplained Weight loss	Yes	No
Swollen lymph nodes	Yes	No
Blood in stool/urine	Yes	No
Swollen/hot joints	Yes	No
New/changing moles	Yes	No
Dry/sensitive skin	Yes	No
History keloids/thick scars	Yes	No
History cold sores/HSV	Yes	No

FOR WOMEN ONLY

Are you pregnant?	Yes	No	Due date: ________________________
Are you breastfeeding?	Yes	No	
Are you on birth control?	Yes	No	If yes, type/name: ____________________

SIGNATURE OF PATIENT __________________________________ Today's Date: ____________

SIGNATURE OF PROVIDER ____