english DERMATOLOGY
HEALTHY SKIN IS OUR PASSION

Date: _____ /_____ / _____

Name: _____ Date Of Birth: _____ / _____ / _____
Last, First

Past Medical History: (mark all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplantation
- ☐ BPH (prostate)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis – A/B/C
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

☐ Other (specify) _____
☐ None

Past Surgical History: (mark all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Breast: Mastectomy (Circle: Right, Left, Both)
- ☐ Breast: Lumpectomy (Circle: Right, Left, Both)
- ☐ Breast Biopsy
- ☐ Breast Reduction
- ☐ C-Section
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Heart: Coronary Artery Bypass
- ☐ Heart: PTCA
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Circle: Right, Left, Both)
- ☐ Joint Replacement, Hip (Circle: Right, Left, Both)
- ☐ Kidney Biopsy
- ☐ Nephrectomy: Kidney Removed (Circle: Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Ovarian Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ Prostate: TURP
- ☐ **Skin Biopsy**
- ☐ **Basal Cell Cancer Surgery**
- ☐ **Squamous Cell Carcinoma Surgery**
- ☐ **Melanoma Surgery**
- ☐ Spleen Removed
- ☐ Testicles Removed (Circle: Right, Left, Bilateral)
- ☐ Tonsilectomy
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer

☐ Other (specify)_____
☐ None

Skin Disease History: (mark all that apply)

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

☐ Other _____
☐ None

Do you have a family history of MELANOMA (NOT the same as basal cell or squamous cell carcinoma)? Yes No

If YES to melanoma, which relative(s)? _____
If YES to melanoma, any other family history (breast, ovarian, pancreatic or prostate cancers)?

_____

Have you had a Pneumonia Vaccine? Yes/NO (circle one) If Yes When? _____
Height _____ Weight _____ BMI _____

Date: _____ /_____ / _____

Name: _____ Date Of Birth: _____ / _____ / _____

Last, First

Medications: (enter all current medications and strengths) ☐ None

Medication:	Strength:

Medication:	Strength:

Medication:	Strength:

Drug Allergies: (do they cause anaphylaxis, angioedema, diarrhea, fatigue, GI upset, hives, liver toxicity, or rash?)

_____ _____ _____

_____ _____ _____

☐ No Known Drug Allergies ☐ Latex

Social History: (mark all that apply)

Illicit Drug Use:
- ☐ Drug Use
- ☐ IV Drug Use

☐ **Cigarette Smoking (REQUIRED):**
- ☐ Current every day smoker
- ☐ Current some day smoker

☐ Former smoker
☐ Never smoker

Alcohol (EtOH) Use:
- ☐ None
- ☐ Less than 1 drink a day
- ☐ 1-2 Drinks per day
- ☐ 3 or more drinks per day

How many times in the past year have you had 5 (for men under age 65) or 4 (for women and all adults older than 65 years) or more drinks in a day?_____

Other_____

Review of Systems: Are you currently experiencing any of the following? (Circle all that apply.)

Problems with bleeding	Fever or chills	Bloody Stool	Cough
Problems with healing	Night sweats	Bloody Urine	Shortness of Breath
Problems with scarring	Unintentional weight loss	Joint Aches	Wheezing
Rash	Thyroid problems	Muscle Weakness	Prone to vasovagal (Fainting)
Immunosuppression	Sore throat	Neck Stiffness	
Hay fever	Blurry vision	Headaches	
Chest Pain	Abdominal Pain	Seizures	

Other Symptoms: _____

Alerts: Are you currently using or experiencing any of the following? (Please check yes or no for the following)

Allergy to adhesive	❑ Yes	Premedication prior to procedures	❑ Yes
Allergiy to lidocaine	❑ Yes	Rapid heart beat with epinephrine	❑ Yes
Allergy to topical antibiotic ointments	❑ Yes	Pregnancy or planning a pregnancy	❑ Yes
Allergy to epinephrine	❑ Yes	HIV Positive	❑ Yes
Aritficial heart valve	❑ Yes	Currently on Biologics	❑ Yes
Artificial Joints within past 2 years	❑ Yes	Deaf	❑ Yes
Blood thinners	❑ Yes	Legally blind	❑ Yes
Defibrillator	❑ Yes	Allergy to latex	❑ Yes
MRSA	❑ Yes	History of cold sores	❑ Yes
Pacemaker or other electrical implanted device	❑ Yes	Currently breastfeeding	❑ Yes

Other Symptoms: _____

PHARMACY (You may ALSO list your mail-order pharmacy - include PHONE and FAX number)

Name _____ Zip Code _____

Address (or major cross-roads if not known): _____

Are you interested in any cosmetic products and/or procedures? Yes No

(Peels, injections, lasers, etc.)