

Printed Patient Name: _____ Date of Birth: _____

REASON FOR VISIT: _____ Today's Date: _____

HOW DID YOU LEARN ABOUT US?	Referral Name
Primary Care Physician	
Another Dermatologist	
Family/Friend/Co-Worker	
Other (Specify)	

CURRENT MEDICATIONS: (Include Vitamins, Supplements, and over the counter medications)

Drug Name	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

MEDICATION ALLERGIES: **No Known Allergies** If yes, complete below:

Name of Medication	Type of Reaction
	rash difficulty breathing stomach pain/vomiting other:
	rash difficulty breathing stomach pain/vomiting other:
	rash difficulty breathing stomach pain/vomiting other:
	rash difficulty breathing stomach pain/vomiting other:

MEDICAL HISTORY: PLEASE CHECK OR FILL IN ALL PHYSICIAN DIAGNOSED MEDICAL CONDITIONS

Skin Cancer:	Immunological Disease:
Melanoma:	Immune Deficiency
Date:	HIV / AIDS
Location:	Lupus or Scleroderma
Squamous Cell Carcinoma:	Rheumatological Disease:
Date:	Osteoarthritis
Location:	Rheumatoid Arthritis
Basal Cell Carcinoma:	Gout
Date:	Psychological / Emotional Disease:
Location:	Depression
Actinic Keratosis (pre-skin cancer):	Obsessive / Compulsive
Date:	Gastrointestinal Disease:
Location:	Cron's Disease, Ulcerative Colitis
Other:	Esophageal Reflux
Date:	Peptic Ulcer
Location:	Esophagitis
Dermatological Disease:	Cardiovascular Disease:
Herpes/Cold Sores	High Blood Pressure
Psoriasis	Heart Problems:
Eczema	Heart Attack: Date:
Acne / Rosacea	Pacemaker / AICD
Blistering disorder:	Irregular Heart Beat
Healing Problems: slow keloid bruising	High Cholesterol
Hematology / Oncology:	Endocrine Disease:
Cancer; type:	Diabetes
Bleeding Problems	Hyperthyroid / Hypothyroid

Neurological Disease:	Liver Disease:
Stroke / Aneurysm	Hepatitis: Type:
Seizure / Epilepsy	Jaundice
Alzheimer's	Lung Disease:
Fainting	Asthma
Kidney Disease:	COPD
Poor Functioning Kidneys	Tuberculosis
Dialysis: type:	Others: Not Listed:
For Female Patients:	
Are you pregnant? YES NO	
Are you Planning pregnancy? YES NO	
Polycystic Ovarian Disease	

SURGERIES:

Type of Surgery	Surgeon	Hospital	Date

FAMILY MEDICAL HISTORY: (PLEASE ADD ANY OTHERS NOT LISTED)

Conditions / Problems	Family Members affected and exact nature of problems
Melanoma	
Non-Melanoma Skin Cancer	
Blistering Disorder	
Auto-Immune Disorder	
Psoriasis	

SOCIAL HISTORY / HABITS

Occupation: _____ Active Retired
 Smoker: Non-Smoker _____packs/day Quit Smoking in _____
 Smokeless Tobacco: YES NO
 Alcohol use: NO YES (# of drinks per week _____)
 Recreational Drug Use: NO YES _____
 Sunscreen Use: Regularly Rarely Never
 Outdoor Activity: _____
 I have traveled outside the United States in the past three months: YES NO

TANNING / SUN EXPOSURE: (mark what describes you best – mark all that apply)

____ Always burn, never tan ____ Rarely Burn, Tan easily
 ____ Usually burn, tan with difficulty ____ At least 1 (one) blistering sunburn
 ____ Sometimes burn, usually tan

Have you ever used a tanning bed, If so, how often: _____ How many years: _____

Patient Printed Name: _____ **DOB:** _____

REVIEW OF SYMPTOMS: (Please mark all of the symptoms you've been having recently)

General	Cardiovascular	Blood / Lymph
Weight Gain / Loss	Swelling of Feet/Ankles	Swollen Glands
Loss of appetite	Musculoskeletal	Fatigue
Weakness	Joint Pain/Swelling	Varicose Veins
Fevers/Chills/Sweats	Back Pain	
	Muscle Pains/Aches	Respiratory
Skin	Neck Pain	Coughing
Skin Rash	Leg Cramps	Wheezing
Itching	Joint Stiffness	Congestion
Lumps	Allergy	Neurological
Dry/sensitive skin	Runny nose	Numbness/Tingling
Hives	Scratchy throat	Headache
Suspicious moles	Itchy eyes	Seizures
Suspicious lesions	Sinus congestion	Dizziness
Jaundice	Sneezing	Psychological
Acne	Hematology	Depression
Hair loss	Easy Bruising	High Stress Level
Ears/Nose/Throat	Gastrointestinal	Suicidal Thinking
Congestion	Nausea / Vomiting	Eating disorder
Change in voice	Abdominal Pain	Mental or physical Abuse
Nose Bleeds	Change in Bowel Habits	Mood Swings
Drainage From Nose	Heartburn/Indigestion	Obsessive-Compulsive Tendencies
Difficulty Swallowing	Genitourinary	
Hoarseness	Pain with Urination	
Sore Throats	Frequent Urination	
Headaches		
Eyes	Other Medical Problems Not Listed:	
Decreased Vision		
Eye Irritation		
Eye Drainage		
Blurry Vision		
Endocrine		
Excessive Sweating		
Excessive Thirst		
Excessive Urination		
Heat Intolerance		
Cold Intolerance		

Patient Printed Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____