NAME:_____ TODAY'S DATE:__/__/____ Office use-Reviewed___

DATE OF BIRTH: __/__/____ Name I prefer to be called: _____ Entered: ___

PAST MEDICAL HISTORY (Please **circle** all that apply) Scanned: ___

Anxiety	End Stage Renal Disease	Leukemia or Lymphoma
Depression	Hearing Loss	Radiation
Arthritis	Heart Attack/Stroke	Cancer: _____
Artificial Joints	Hepatitis B or C	Other: _____
Diabetes	HIV/AIDS	None

PAST SKIN DISEASE HISTORY (Please **circle** all that apply)

Actinic Keratoses	Melanoma	Other:_____
Basal Cell Carcinoma	Squamous Cell Carcinoma	None

PAST SURGICAL HISTORY (Please **circle** all that apply)

Heart Valve Replacement	Other: _____
Joint Replacement	None

□ Do you have an immediate family history of melanoma? **Yes** or **No**. If yes, Mother Father Sister Brother or Child
□ Are there any pertinent or major skin problems that run in your family? _____

MEDICATIONS (Please **list** all your medications, including vitamins and supplements, doses & frequencies, tablet or liquid)

			SEE LIST

ALLERGIES TO MEDICATIONS (Please **list** any medication allergies and the **type of reaction** that occurred)

_____

PHARMACY (Please provide the pharmacy name and general location)

_____

PRIMARY CARE DOCTOR: _____REFERRING DOCTOR:_____

DERMATOLOGY ALERTS (Please **circle** any of these important alerts if they apply to you)

Allergy to lidocaine	Artificial heart valve	Defibrillator
Rapid heartbeat with epinephrine	Artificial joints within last 2 years	Pacemaker
Allergy to adhesive	Premedication prior to procedures	Pregnant, planning or nursing
Allergy to topical antibiotics	Blood thinners	Other_____

□ What is your current and/or former occupation? _____
□ What type of outdoor activities, if any, do you participate in? _____
□ Do you have any other hobbies or activities you would like us to know about? _____
□ Do you have any children or pets? _____
□ With whom, if anyone, do you live? _____
□ Where do you live (generally speaking: what town or city or county, assisted living facility)? _____

PLEASE DETAIL THE REASON FOR TODAY'S VISIT

	Problem 1	Problem 2
Problem (e.g. growth(s) or rash or follow-up for a skin condition?)		
Location (site on body?)		
Quality (stable, asymptomatic, itch, bleed, tender, scaly, rough, darker, enlarging?)		
Severity (mild, moderate, or severe?)		
Duration (how long?)		
Previous treatments (OTC, prescriptions or other?)		
What makes it better or worse?		

Do you have any other rashes? YES or NO
Do you have any problems with allergy or your immune system? YES or NO
Are you under significant stress? YES or NO
Do you have problems with scarring? YES or NO
Do you have problems with healing? YES or NO
Do you have problems with bleeding? YES or NO

Advanced Dermatology & Skin Surgery
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