THE DERMATOLOGY CLINIC

Name: _____

Birthdate: _____

Past Medical History

None ☐

Please select any of the following conditions that you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplantation
- ☐ Benign Prostatic Hyperplasia
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Other (Enter Below)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

Physician List:

Please list the name and location of your physicians:

1. Primary care physician: _____
2. Other: _____
3. Other: _____
4. Other: _____

THE DERMATOLOGY CLINIC

Past Surgeries

None ☐

Please list any prior surgeries that you have had:

Skin Disease History

None ☐

Have you had any of the following conditions?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal cell skin cancer
- ☐ Blistering sunburns
- ☐ Dry skin
- ☐ Eczema
- ☐ Other skin conditions:
- ☐ Flaking or itchy scalp
- ☐ Hay fever/allergies
- ☐ Melanoma
- ☐ Precancerous moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer

Do you wear sunscreen? If yes what SPF? _____

☐ Yes ☐ No

Do you tan in a tanning salon?

☐ Yes ☐ No

Do you have a family history of melanoma? If yes which relative ? _____

☐ Yes ☐ No

THE DERMATOLOGY CLINIC

Have you had any of the following conditions?

	YES	NO
☐ Allergy to lidocaine	☐	☐
☐ Allergy to topical antibiotic ointments	☐	☐
☐ Artificial heart valve	☐	☐
☐ Artificial joints within past two years	☐	☐
☐ Blood thinners	☐	☐
☐ Defibrillator	☐	☐
☐ MRSA	☐	☐
☐ Pacemaker	☐	☐
☐ Premedication prior to procedures	☐	☐
☐ Rapid heartbeat with epinephrine	☐	☐
☐ Currently pregnant or planning a pregnancy	☐	☐

Medications:

None ☐

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Allergies:

No Known Drug Allergies ☐

Please list any medication allergies you have and what your reaction was.

	Drug	**Reaction**
1.		
2.		
3.		

Please list at which pharmacy you prefer to have your prescriptions filled:

Pharmacy Name: _____

Street Address: _____

City, State: _____

Phone: _____

Fax: _____

Mail order: ☐ Yes ☐ No