is now a part of U.S. DERMATOLOGY partners

Patient Name: _____ **Preferred Name**: _____ **Date of Birth**: _____
May we take your picture for your medical chart? □ YES □ NO
*Your photo is for internal use and identification purpose only and will not be shared.

Primary Care Physician: _____ **Referred by:** _____
Pharmacy Name: _____ **Pharmacy Address:** _____ **Pharmacy Phone:** _____

Past Medical History: (please check all that apply)

❑ Anxiety	❑ Depression	❑ Hyperthyroidism
❑ Arthritis	❑ Diabetes	❑ Hypothyroidism
❑ Asthma	❑ End stage renal disease	❑ Leukemia
❑ Atrial fibrillation	❑ GERD (reflux)	❑ Lung cancer
❑ Bone marrow transplant	❑ Hearing loss	❑ Lymphoma
❑ BPH (enlarged prostate)	❑ Hepatitis	❑ Prostate cancer
❑ Breast cancer	❑ Hypertension (high blood pressure)	❑ Radiation treatment
❑ Colon cancer	❑ HIV/AIDS	❑ Seizures
❑ COPD	❑ Hypercholesterolemia (high cholesterol)	❑ Stroke
❑ Coronary artery disease		

Other:

Past Surgical History: (please check all that apply)

❑ Appendix removed
❑ Bladder removed
❑ Breast biopsy □ **right** □ **left** □ **bilateral**
❑ Lumpectomy □ **right** □ **left** □ **bilateral**
❑ Mastectomy □ **right** □ **left** □ **bilateral**
❑ Colon resection
❑ Gallbladder removed
❑ Coronary artery bypass
❑ Angioplasty (PTCA)
❑ Biological valve replacement
❑ Mechanical valve replacement
❑ Heart transplant
❑ Hip replacement □ **right** □ **left** □ **bilateral**
Within the last 2 years? □ YES □ NO
❑ Knee replacement □ **right** □ **left** □ **bilateral**
Within the last 2 years? □ YES □ NO
❑ Kidney biopsy
❑ Kidney removed □ **right** □ **left**
❑ Kidney stone removal
❑ Kidney transplant
❑ Hepatectomy □ **liver surgery** □ **biopsy**
❑ Liver transplant
❑ Liver shunt
❑ Ovaries removed
□ **endometriosis** □ **cancer** □ **cyst**
□ **other** _____
❑ Pancreas removed
❑ Prostate removed □ **cancer** □ **TURP**
❑ Skin Biopsy □**BCC** □ **SCC** □ **Melanoma**
❑ Spleen removed
❑ Hysterectomy
□ **fibroids** □ **uterine cancer** □ **cervical cancer**
□ **other** _____

Other:

Skin Disease History: (please check all that apply)

❑ Acne	❑ Dry skin	❑ Poison Ivy
❑ Actinic keratosis	❑ Eczema	❑ Precancerous moles
❑ Asthma	❑ Flaking/itchy scalp	❑ Psoriasis
❑ Basal cell skin cancer	❑ Hay fever/allergies	❑ Squamous cell skin cancer
❑ Blistering sunburns	❑ Melanoma	

Other:

Continued on next page….

DO YOU WEAR SUNSCREEN? □ **YES** □ **NO** *If yes, what SPF:* _____
DO YOU TAN IN A TANNING SALON? □ **YES** □ **NO**
DO YOU WANT TO DISCUSS SKIN CARE? □ **YES** □ **NO**

Medications (please list all current medications including over the counter)

Name	Dose	Frequency

❑ **No medications**

Drug Allergies

_____ _____

_____ _____

❑ **No known drug allergies**

Family History

	Father	Mother	Brother	Sister	Son	Daughter
❑ Skin Cancer (BCC, SCC or Atypical Mole)	□	□	□	□	□	□
❑ Malignant Melanoma	□	□	□	□	□	□
❑ Unknown	□	□	□	□	□	□
❑ Adopted						
❑ None						

Alerts (please check all that apply or check here if not applicable)

❑ Allergy to adhesive	❑ Blood thinners	❑ Breast feeding
❑ Allergy to topical antibiotics	❑ Defibrillator	❑ Require antibiotics prior to procedure
❑ Allergy to lidocaine	❑ GI upset with antibiotics	❑ Rapid heartbeat with epinephrine
❑ Artificial heart valve	❑ Pacemaker	❑ Yeast infections with antibiotics
❑ Artificial joints within last 2 years	❑ Premedication prior to procedure	

Are you pregnant or currently trying to get pregnant? □ YES □ NO

Review of Systems: Are you currently experiencing any of the following?

Symptom	Yes	No	Symptom	Yes	No
Are you in generally good health?			Do you currently have a rash?		
Do you have problems with bleeding?			Do you have any new skin lesions?		
Do you have problems with healing?			Do you have any changing skin lesions?		
Do you have problems with scarring?					