DERMATOLOGY ASSOCIATES, P.A.

Patient Information

Name _____
(Last) (First) (Middle) (Maiden) Date

Age _____ Date of Birth _____

History of Present Skin Complaint

What is your primary skin concern / reason for today's visit?

_____

Where on your body is the problem located?

_____

Describe any symptoms (pain, itching, tenderness, irritation, burning, bleeding)

_____

How severe is the skin problem: ❑ Mild ❑ Moderate ❑ Severe

How long have you had the skin problem? _____

Describe any past or current treatment for this problem (OTC / Rx / Surgery)

_____

_____

Are there any other skin concerns that you would like to have evaluated at this time (describe)?

_____

Medical History - Do you or have you ever had any of the following medical conditions:

Anxiety / Depression	Y	N	Hearing Loss	Y	N
Arthritis	Y	N	Hepatitis	Y	N
Asthma	Y	N	Hypertension	Y	N
Atrial Fibrillation	Y	N	HIV / AIDS	Y	N
Bone Marrow Transplant	Y	N	High Cholesterol	Y	N
COPD	Y	N	Thyroid Disease	Y	N
Coronary Artery Disease	Y	N	Seizures	Y	N
Diabetes	Y	N	End Stage Kidney Disease	Y	N
GERD	Y	N	Cancer	Y	N _____

Past Surgical History - Have you had any of the following surgeries:

Appendix	Y	N	Breast	Y	N
Colon	Y	N	Heart	Y	N _____
Kidney	Y	N	Joint Replacement	Y	N _____
Ovaries	Y	N	Pregnancy / Childbirth	Y	N
Prostate	Y	N	Skin Cancer	Y	N (Basal Cell / Squamous Cell/ Melanoma)
Gallbladder	Y	N			

OVER

Skin Disease History - Have you had any of the following conditions:

Acne	Y	N	Scalp Condition	Y	N
Actinic Keratosis	Y	N	Hay Fever / Allergies	Y	N
Blistering Sunburns	Y	N	Atypical Moles	Y	N
Dry Skin	Y	N	Psoriasis	Y	N
Eczema	Y	N			

Do you wear ***sunscreen***? Y N SPF _____

Have you used ***tanning beds***? Y N How often? _____

Family History

Do you have a family history of **Malignant Melanoma** (NOT Basal Cell or Squamous Cell Carcinoma) Y N

If so, which relative(s) _____

Medications - Please list all **prescription** *and* **OTC** medications:

_____

_____

_____

_____

Allergies to Medication (Penicillin, Sulfa, Cephalosporins, Local Anesthetic): _____

_____

Social History

Do you smoke Y N Do you use smokeless tobacco Y N

Do you drink alcohol Y N What is your occupation _____

Review of Systems

Do you have a Pacemaker	Y	N	
Do you have a Defibrillator	Y	N	
Have you had joint replacement surgery in the past two years	Y	N	hip / knee / other
Do you have an artificial heart valve	Y	N	
Do you need antibiotics before procedures	Y	N	
Are you taking blood thinners	Y	N	aspirin / Coumadin / plavix / vitamin E
Are you pregnant or planning pregnancy	Y	N	
Are you allergic to latex	Y	N	
Are you allergic to adhesive	Y	N	
Are you allergic to topical antibiotic ointment	Y	N	

Do you have any symptoms with any other body area that you feel are related to your present skin condition?

(such as fever, headache, joint or muscle pain, fatigue, depression) _____

_____

Thank You!