AFFILIATED DERMATOLOGISTS

PATIENT HISTORY FORM

Date: _____

Name: _____

Last First Middle

Birthdate: _____

Primary Care Physician: _____ Referring Provider: _____

Your Occupation: _____

Preferred Pharmacy: _____/_____/_____

Name Address Phone

Mail Order Pharmacy: _____

Do you take any prescription medications, including vitamins or supplements? Yes / No
If yes, please list below:

Do you have allergies to medication? Yes / No
(If yes, please list and give type of reaction:

1. _____
2. _____
3. _____

Past Medical History (circle yes or no):

Abnormal Moles	Yes / No	Cancer-List Type	Yes / No
Eczema	Yes / No	Liver Disease / Hepatitis	Yes / No
Asthma	Yes / No	High Blood Pressure	Yes / No
Seasonal Allergies / Hay fever	Yes / No	Pacemaker	Yes / No
Hypo / Hyper Thyroidism	Yes / No	Mitral Valve Prolapse	Yes / No
Diabetes	Yes / No	Heart Valve Replacement	Yes / No
Arthritis	Yes / No	Joint Replacement	Yes / No
Autoimmune Disease	Yes / No	Blood disorder	Yes / No
HIV	Yes / No		

Please flip over to complete side 2

Do you have other medical conditions not listed above?

_____

_____

If you checked Cancer above, please list type here: _____

Past Family & Personal Medical History:

	Personal	Family	Details
Basal CellCarcinoma			
Squamous Cell Carcinoma			
Malignant Melanoma			
Psoriasis			

Past Surgical History and Hospitalizations: (List All)

_____

_____

_____

Please circle yes or no:

Do you wear sunscreen?	Yes / No
Do you use indoor tanning?	Yes / No
Have you ever had a severe reaction to local anesthesia?	Yes / No
Are you allergic to adhesive?	Yes / No
Are you allergic to topical antibiotic ointments?	Yes / No
Are you taking blood thinners?	Yes / No
Have you been told to take antibiotics prior to dental or surgical procedures?	Yes / No
Have you had an adverse reaction to epinephrine?	Yes / No
Are you pregnant or planning a pregnancy?	Yes / No

Number of alcoholic drinks per day?

○ None ○ Less than 1 per day ○ 1-2 per day ○ 3 or more per day

Smoking Status

○ Current, everyday ○ Current some days ○ Former ○ Never

Skin Type

If you were first exposed to the summer sun without sunscreen, would you:

○ 1. Always burn, never tan
○ 2. Always burn, sometimes tan
○ 3. Sometimes burn, always tan gradually
○ 4. Burn minimally, always tan well
○ 5. Rarely burn, tan profusely
○ 6. Never burn, deeply pigmented