

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			

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 <i>sunscreen</i> ?	Y	N	SPF _____		
Have you used <i>tanning beds</i> ?	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!