

Today's Date: \_\_\_\_\_

*If you answer "YES" to a particular question, please elaborate in the space provided.*

<b>Patient Name:</b>	<b>Date of Birth:</b>	<b>Age:</b>	<b>Sex:</b>	<b>Weight:</b>
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**Reason for today's visit (circle ONE):** RASH MOLES BUMPS SKIN CANCER PSORIASIS ACNE COSMETIC OTHER:

Did your doctor request you been seen by a Dermatologist? Referring doctors name:  
Do you want us to send a report back to your doctor? NO YES

**1. Medications (including doses): Please list current ones (including herbal or homeopathic):**

**2. Allergies: Are you allergic to medications or do you have general allergies?** NO YES– please list:

**3. Skin History: Have you ever visited a Dermatologist?** NO YES– Reason/Approx Date:

Have you ever had skin cancer?	<input type="checkbox"/> NO <input type="checkbox"/> YES- type:
Do you have a history of MELANOMA?	<input type="checkbox"/> NO <input type="checkbox"/> YES(personal) <input type="checkbox"/> YES(family)
Do you have a history of atypical moles / precancers?	<input type="checkbox"/> NO <input type="checkbox"/> YES
Do you have a history of specific skin diseases?	<input type="checkbox"/> NO <input type="checkbox"/> YES
Do you form Keloids (thick scars)?	<input type="checkbox"/> NO <input type="checkbox"/> YES

Do you actively "seek a tan" (laying in sun / tanning beds?)	<input type="checkbox"/> NO <input type="checkbox"/> YES
Do you regularly use sunscreen?	<input type="checkbox"/> NO <input type="checkbox"/> YES
Have you ever had blistering sunburns?	<input type="checkbox"/> NO <input type="checkbox"/> YES
When exposed to the sun, do you	<input type="checkbox"/> Tan only <input type="checkbox"/> Tan and Burn <input type="checkbox"/> Burn
Please describe your CURRENT (last 2 years) sun exposure:	<input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Maximal
Please describe your CHILDHOOD (first 18 years) sun exposure:	<input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Maximal

**4. General Medical** Do you now have, of have you ever had

Asthma	<input type="checkbox"/> NO <input type="checkbox"/> YES	Seizures	<input type="checkbox"/> NO <input type="checkbox"/> YES	Arthritis	<input type="checkbox"/> NO <input type="checkbox"/> YES
Seasonal allergies	<input type="checkbox"/> NO <input type="checkbox"/> YES	Depression	<input type="checkbox"/> NO <input type="checkbox"/> YES	Ulcers/Reflux	<input type="checkbox"/> NO <input type="checkbox"/> YES
High BP	<input type="checkbox"/> NO <input type="checkbox"/> YES	Thyroid Disease	<input type="checkbox"/> NO <input type="checkbox"/> YES	Liver prbl/Hepatitis	<input type="checkbox"/> NO <input type="checkbox"/> YES
Phlebitis	<input type="checkbox"/> NO <input type="checkbox"/> YES	Diabetes	<input type="checkbox"/> NO <input type="checkbox"/> YES	HIV Infection	<input type="checkbox"/> NO <input type="checkbox"/> YES
Heart Valve Dis.	<input type="checkbox"/> NO <input type="checkbox"/> YES	Glaucoma	<input type="checkbox"/> NO <input type="checkbox"/> YES	Cancer	<input type="checkbox"/> NO <input type="checkbox"/> YES
Blood clots	<input type="checkbox"/> NO <input type="checkbox"/> YES	Cataracts	<input type="checkbox"/> NO <input type="checkbox"/> YES	Fever blister	<input type="checkbox"/> NO <input type="checkbox"/> YES

Have you ever had local or dental anesthesia? NO YES– did you have a bad reaction? NO YES-elaborate:

Do you take antibiotics before dental appointments?	<input type="checkbox"/> NO <input type="checkbox"/> YES	Do you smoke?	<input type="checkbox"/> NO <input type="checkbox"/> YES
Are you pregnant or breastfeeding?	<input type="checkbox"/> NO <input type="checkbox"/> YES	Do you drink alcohol?	<input type="checkbox"/> NO <input type="checkbox"/> YES

List surgical procedures you have had in the last 6 months:

List any medical condition you are currently being treated for:

**5. Family History:** Do you any blood relatives with a history of skin cancer? NO RELATIVE

Marital Status: single married divorced widowed separated partnered

**6. Are you interested in INFORMATION on any of the following?**

<input type="checkbox"/> Skin Care / Skin Care Products	<input type="checkbox"/> Sun Screen	<input type="checkbox"/> Liposuction	<input type="checkbox"/> Hair Removal	<input type="checkbox"/> Botox	<input type="checkbox"/> Foto Facial
<b>Cosmetic procedures:</b> <input type="checkbox"/> Eyes	<input type="checkbox"/> Lips	<input type="checkbox"/> Wrinkles	<input type="checkbox"/> Skin Tightening		

**Signature (Patient OR Care Giver) :** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If, Care Giver, Relationship to Patient:**