Valley Dermatology Associates, INC., P.S.

Medical History

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height:\_\_\_\_ Weight:\_\_\_\_ Sex: M/F/T Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated by another dermatologist? Yes/ No

If so, whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle all that apply for today’s visit:

|  |  |  |  |
| --- | --- | --- | --- |
| Location:Scalp Face BodyArm R/L Leg R/LOther:\_\_\_\_\_\_\_\_ | Symptoms:Dry/Flaking BlisteringItching Scaling BleedingGrowth Recent ChangeBurning Stinging Acne | Duration:Days:\_\_\_\_\_Weeks:\_\_\_\_Months:\_\_\_Years:\_\_\_\_ | Previous treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Have you ever had any skin cancer? Yes/ No

If yes, check all that apply:

Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma:\_\_\_\_\_\_\_\_\_\_\_\_

The location of the cancer and date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has anyone in your family had Melanoma? Yes/No Whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle all that apply:

|  |  |
| --- | --- |
| Skin History: Excessive sun exposure Use of tanning bedAccutane treatment Radiation exposure Blistering sunburnsDo you use Sunscreen: Yes/ No | Social History:Do you smoke? Yes/ No How much\_\_\_\_Do you drink alcohol? Yes/ No Socially Occasionally Often/DailyWhat is your occupation:\_\_\_\_\_\_\_\_\_\_\_  |

 **Medical History**

Do you now, or have you ever had any of the following conditions? Please circle all that apply:

Anxiety Diabetes High Blood Pressure

Asthma Eczema HIV/ AIDS

Artificial Joints Yes/ No Excessive Hair Growth Hives

-What\_\_\_\_\_ Emphysema/ COPD Keloids

-When\_\_\_\_\_ Heart Condition Lupus

Bleeding problems - Pace Maker Shingles

Chronic Cough -Artificial Valve Seasonal Allergy

Cold Sores -Cardiac Stent Thyroid Disease

Depression -Irregular heart beat TB/ Tuberculosis

 PLEASE SEE BACK OF PAGE

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Have you had an organ transplant? Yes/ No

Please Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had cancer not including the skin? Yes/ No

Please Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all the medications you are taking. Include any herbal, vitamins or supplements.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been vaccinated for- Influenza Pneumonia Shingles

Allergies to medications? Yes/ No

Please List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to adhesive tape? Yes/ No

Are you pregnant or planning a pregnancy? Yes/ No

Are you allergic to Latex? Yes/ No

Are you allergic to any anesthesia? Yes/ No

-Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any blood thinning medications? Yes/ No

What is your preferred local pharmacy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use a mail-order pharmacy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the best phone number to reach you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or personal representative Date

Reviewed by \_\_\_\_\_\_\_\_