Name: ____________________________________ Date of Birth: ___________________________

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
Dialysis
GERD (Acid Reflux)
Hearing Loss
Hepatitis
High Blood Pressure
High Cholesterol
HIV/AIDS
Hyperthyroidism (high)
Hypothyroidism (low)
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
Yeast Infections with antibiotics
Difficulty Taking Pills
NONE

Other ____

Past Surgical History (please circle all that apply)

Appendix Removed
Bladder Removal
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA (angioplasty)
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removal (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Carcinoma Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
NONE

Other ____

Have you previously seen a dermatologist? Yes or No Name if yes ______________________________

Skin Disease History

Acne	Keloids/Thick Scars
Basal Cell Carcinoma	Poison Ivy
Blistering Sunburns	Precancerous Moles
Dry Skin	Precancerous Lesions
Eczema	Psoriasis
Flaking or Itchy Scalp	Squamous Cell Carcinoma

Other ____

Do you wear sunscreen? Yes or No Yes, what SPF ________

Do you use a tanning bed? Yes or No Have you previously used a tanning bed? Yes or No

Are you Pregnant? Yes (due date ___________) No Are you breast feeding? Yes or No

Medications: If you have a list please give to the receptionist to copy. Please list all medications you take prescription and over the counter.

_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________

******Permission to pull medications from pharmacy if available? Yes or No***

Allergies: Please list all allergies and the reaction you had.

_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________

Family History: Has any blood relative ever had the following: (please list relation to you)

Breast Cancer	_________________________	High Cholesterol	_________________________
Basal Cell Carcinoma	_________________________	Melanoma	_________________________
Diabetes	_________________________	Squamous Cell Carcinoma	_________________
Heart Disease	_________________________	Stroke	_________________________
High Blood Pressure	_________________________	Other	_________________________

Cigarette Smoking:	**Alcohol Use:**	**Language:**
Never Smoked	Yes (<1 2-3 4+ drinks per day)	English
Quit: former smoker	No	Spanish
Smokes less than daily		Other: ____________________
Smokes daily		

***** Number of packs per day _______ Total Years smoking _________***

*****How many times in the past year have you had 5 or more drinks in a day for men, 4 or more drinks in a day for women or any adult older than 65? ____________***

Race:
White
Black/African
Asian
American Indian or Native Alaskan
Native Hawaiin/Pacific Islander

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

How often do you exercise?
Once a day
A few times a week
A few times a month
Never

What is your caffeine use?
Once a day
A few times a week
A few times a month
Never

Your occupation and workplace: ____

Your county of residence: ____