Center for Advanced Dermatology

Patient Name: _____ **DOB:** _____

PCP:_____ **Referring Doctor:**_____

Pharmacy: Name_____**Address**_____**Phone**_____

Past Medical History: (please check all that apply)

☐ Anxiety	☐ Depression	☐ Hyperthyroidism
☐ Arthritis	☐ Diabetes	☐ Hypothyroidism
☐ Asthma	☐ End stage renal disease	☐ Leukemia
☐ Atrial fibrillation	☐ GERD (reflux)	☐ Lung cancer
☐ Bone marrow transplant	☐ Head trauma	☐ Lymphoma
☐ BPH (enlarged prostate)	☐ Hearing loss	☐ Prostate cancer
☐ Breast cancer	☐ Hepatitis	☐ Radiation treatment
☐ Colon cancer	☐ Hypertension (high blood pressure)	☐ Seizures
☐ COPD	☐ HIV / AIDS	☐ Stroke
☐ Coronary artery disease	☐ Hypercholesterolemia (high cholesterol)	

Other:

Past Surgical History: (please check all that apply)

☐ Appendix removed	☐ Kidney biopsy
☐ Bladder removed	☐ Kidney removed (right, left)
☐ Breast Biopsy (right, left, bilateral)	☐ Kidney stone removal
☐ Lumpectomy (right, left, bilateral)	☐ Kidney transplant
☐ Mastectomy (right, left, bilateral)	☐ Hepatectomy (liver surgery or biopsy)
☐ Colectomy	☐ Liver transplant
☐ Colostomy	☐ Liver shunt
☐ Gallbladder removed	☐ Ovaries removed: (endometriosis, cancer, cyst)
☐ Coronary artery bypass	☐ Pancreas removed
☐ Angioplasty (PTCA)	☐ Prostate removed: (cancer, TURP)
☐ Biological valve replacement	☐ Rectal resection
☐ Mechanical valve replacement	☐ Skin Biopsy (☐ BCC, ☐ SCC, ☐ Melanoma)
☐ Heart transplant	☐ Spleen removed
☐ Hip replacement (right, left, bilateral)	☐ Testicles removed (right, left, bilateral)
☐ Knee replacement (right, left, bilateral)	☐ Hysterectomy (fibroids, uterine cancer, cervical cancer)

Other:

Skin Disease History: (please check all that apply)

☐ Acne	☐ Dry skin	☐ Poison Ivy
☐ Actinic keratosis	☐ Eczema	☐ Precancerous moles
☐ Asthma	☐ Flaking/itchy scalp	☐ Psoriasis
☐ Basal cell skin cancer	☐ Hay fever/allergies	☐ Squamous cell skin cancer
☐ Blistering sunburns	☐ Melanoma	

Other:

DO YOU WEAR SUNSCREEN? ☐ YES ☐ NO

If yes, what SPF: _____

DO YOU TAN IN A TANNING SALON?

☐ YES ☐ NO

DO YOU HAVE A FAMILY HISTORY OF MALIGNANT MELANOMA? ☐ YES ☐ NO

If yes, which relative(s): _____

DO YOU WANT TO DISCUSS SKIN CARE? ☐ YES ☐ NO

MEDICATIONS (please list all current medications including over the counter):

_____ _____

_____ _____

_____ _____

_____ _____

☐ NO MEDICATIONS

DRUG ALLERGIES (please list all known allergies and reactions):

_____ _____

_____ _____

☐ NO KNOWN DRUG ALLERGIES

SOCIAL HISTORY:

Smoking status: ☐ Current every day smoker ☐ Current someday smoker ☐ Former smoker ☐ Never

Occupation: _____

FAMILY HISTORY:

- ☐ Malignant neoplasm of skin (BCC, SCC or Atypical/Precancerous Mole)
- ☐ Unknown
- ☐ Adopted

ALERTS: (please circle all that apply)		
☐ Allergy to adhesive	☐ Blood thinners	☐ Breast feeding
☐ Allergy to topical antibiotics	☐ Defibrillator	☐ Require antibiotics prior to procedure
☐ Allergy to lidocaine	☐ GI upset with antibiotics	☐ Rapid heartbeat with epinephrine
☐ Artificial heart valve	☐ Pacemaker	☐ Yeast infections with antibiotics
☐ Artificial joints within last 2 years	☐ Premedication prior to procedure	

ARE YOU PREGNANT OR CURRENTLY TRYING TO GET PREGNANT? ☐ YES ☐ NO

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (Please check yes or no)

Symptom	Yes	No
Are you in generally good health?		
Do you have problems with bleeding?		
Do you have problems with healing?		
Do you have problems with scarring?		
Do you currently have a rash?		
Do you have any new skin lesions?		
Do you have any changing skin lesions?		