**Advanced Dermatology & Skin Cancer Center**

 Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age:\_\_\_\_\_\_\_\_Sex:\_\_\_\_\_\_\_\_\_Today’s Date\_\_\_\_/\_\_\_\_/\_\_\_\_

 **Review of Symptoms**

 **Please check any of the following that you have or have had recently:**

 \_\_Fever/Chills \_\_Nausea/Vomiting \_\_Rash \_\_Itching

 \_\_Weight Changes \_\_Diarrhea \_\_Skin Color Changes \_\_Hair Changes

 \_\_Heartburn \_\_Constipation \_\_Nail Changes \_\_Swelling Ankles

 **Do you take Aspirin? Yes No Coumadin(warfarin)? Yes No Ibuprofen? Yes No Plavix? Yes No**

 ***PLEASE USE THE BACK OF THIS SHEET TO LIST MEDICATIONS AND ALLERGIES -🡪 🡪***

 **Have you ever had any of the following?(Please Check)**

\_\_Herpes I (fever blisters) \_\_Diabetes \_\_Seizures \_\_Malignant Moles

 \_\_Herpes II \_\_High Blood Pressure \_\_Anemia \_\_Skin Cancer

 \_\_Hepatitis \_\_High Cholesterol \_\_Thyroid Disease \_\_Scarring

 \_\_HIV \_\_Heart Attack \_\_Arthritis \_\_Bleeding Tendency

 \_\_Tuberculosis \_\_Artificial Heart Valve \_\_Lung Disease \_\_Artificial Joints

 \_\_Asthma \_\_Bad Veins \_\_Kidney Disease \_\_Organ Transplant

 \_\_Hay fever \_\_Mitral Valve Prolapse \_\_Eye Disease \_\_Chemotherapy

 \_\_Eczema \_\_Pacemaker \_\_Liver Disease \_\_X-Ray Treatments

 \_\_Reaction to local anesthesia \_\_Bruise Easily \_\_Other:\_\_\_\_\_\_\_\_\_\_\_ \_\_Other:\_\_\_\_\_\_\_\_\_\_

 **Which is true for you? (check)** \_\_\_Always burn – Never tan \_\_Always burn – Sometimes tan

 \_\_\_Sometimes burn – Always tan \_\_Never burn – Always tan

 **How many blistering sunburns have you had? \_\_\_\_\_\_ Sunscreen Use (use):** \_\_\_Daily \_\_\_Sometimes \_\_\_Never

 **Females only: Are you pregnant? (circle) Yes No Are you planning to become pregnant? (circle) Yes No**

 **Family History: Medical conditions that have occurred in your family (check):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Disease/Condition** | **Mother** | **Father** | **Sibling****(*Brother/Sister*)** | **Other Blood Relative** | **Comments** |
| **Allergies** |  |  |  |  |  |
| **Arthritis** |  |  |  |  |  |
| **Cancer** |  |  |  |  |  |
| **Diabetes** |  |  |  |  |  |
| **Eczema** |  |  |  |  |  |
| **Heart Disease** |  |  |  |  |  |
| **High Blood Pressure** |  |  |  |  |  |
| **Lung Disease** |  |  |  |  |  |
| **Malignant Melanoma** |  |  |  |  |  |
| **Psoriasis** |  |  |  |  |  |
| **Skin Cancer** |  |  |  |  |  |
| **Tuberculosis** |  |  |  |  |  |

 **Social History**

 **Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hobbies/Leisure Activities:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Do you smoke? Yes No \_\_\_\_\_packs/day Do you drink alcohol? Yes No Do you use recreational drugs? Yes No**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ***OFFICE USE ONLY***

 **Changes to Medical History Initials Date Changes to Medical History Initial Date**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_**

 **Reviewed by Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\*\*\*\*\*\*\*\*\*\*\*\*\*\* *OVER FOR MEDICATIONS/ALLERGIES LIST -----🡪***

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Medication** | **Dose** | **How often do you take it?** | **Mode of administration** |
| **1** |  |  |  |
| 2 |  |  |  |
| **3** |  |  |  |
| **4** |  |  |  |
| **5** |  |  |  |
| **6** |  |  |  |
| **7** |  |  |  |
| **8** |  |  |  |
| **9** |  |  |  |
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| **16** |  |  |  |
| **17** |  |  |  |
| **18** |  |  |  |
| **19** |  |  |  |
| **20** |  |  |  |

|  |
| --- |
| **List any known drug allergies** |
| **1** |
| **2** |
| **3** |
| **4** |

|  |
| --- |
| **List any other allergies (food, seasonal, etc)** |
| **1** |
| **2** |
| **3** |
| **4** |