**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**

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***OFFICE USE ONLY***

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

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**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** |