Name _____ Gender _____ Age _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

Please describe any previous skin problems you have had.

Current Medications

Are you currently taking any blood thinners?

☐ Yes ☐ No

What medications are you currently taking?

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name	Reaction

Skin

Do you have any of the following?

☐ Abnormal Moles ☐ Cold Sores ☐ Psoriasis
☐ Acne ☐ Dry / Sensitive Skin ☐ Rash
☐ Boils ☐ Eczema ☐ Rosacea
☐ Bleed Easily ☐ Hives ☐ Scars
☐ Changes in Moles ☐ Itching ☐ Sores That Won't Heal
☐ Chills

Have you ever had a biopsy for a suspicious growth?

☐ Yes ☐ No

When you are exposed to the sun do you:

☐ Tan Only ☐ Tan and Burn ☐ Burn Only

Have you visited tanning salons or do you sunbathe?

☐ Yes ☐ No

Do you regularly apply sunblock to exposed areas?

☐ Yes ☐ No If yes, which SPF? _____

Have you ever had skin cancer?

☐ Yes ☐ No If yes, what type? _____

When? _____ Where? _____

Past Medical History

Have you ever had any of the following?

☐ Alcoholism ☐ Bleeding Disorder ☐ Eating Disorder
☐ Allergies ☐ Blood Disease ☐ Epilepsy
☐ Anemia ☐ Blood Transfusion ☐ Hay Fever
☐ Anxiety Disorder ☐ Bowel Disorder ☐ Heart Disease
☐ Arthritis ☐ Cancer ☐ Heart Problems
☐ Asthma ☐ Diabetes ☐ Hepatitis - A, B, or C
☐ AIDS / HIV ☐ Depression ☐ High Blood Pressure
☐ High Cholesterol ☐ Migraines ☐ Stomach Ulcer
☐ Joint Disorder ☐ Osteoporosis ☐ Substance Abuse
☐ Kidney Disorder ☐ Pacemaker ☐ Thyroid Disorder
☐ Liver Disorder ☐ Rheumatic Fever ☐ Tuberculosis
☐ Lung Disease ☐ Sinus Problems ☐ Venereal Disease
☐ Lupus ☐ Skin Disorder
☐ Measles ☐ Stroke

Hospitalizations & Surgeries

Reason	Date

Women Only

Are you pregnant?

☐ Yes ☐ No

Are you breastfeeding?

☐ Yes ☐ No

Family History

Has anyone in your family ever had any of the following conditions?

☐ Abnormal Moles ☐ Basal Cell Carcinoma ☐ Melanoma
☐ Acne ☐ Cancer ☐ Psoriasis
☐ Allergies ☐ Diabetes ☐ Skin Cancer
☐ Arthritis ☐ Eczema ☐ Squamous Cell Carcinoma
☐ Asthma

Details: _____

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____