Adult and Pediatric Dermatology

Patient Name: _____ **Date of Birth:** _____

Are you allergic to any medications? __Yes __No If yes, which: _____

Have you ever had a bad/allergic reaction to any of the following: (Circle)

Latex Lidocaine Epinephrine Betadine Iodine Adhesives

List all the medication/vitamins/over the counter/herbal medications you are currently taking:

_____

_____

Do you have, or have you ever had any of the following conditions: (Circle)

Bronchitis/Emphysema
Asthma
Shortness of Breath
Heart attack/ angina
Chest Pain
Heart murmur
Irregular heart beat
Heart Failure
Phlebitis/ blood clots
Pacemaker
Fainting with medical procedures
Hay fever
Ear/nose/sinus/throat problems
Diabetes
Thyroid condition
Kidney disease
Dialysis
Bladder problems
Gastrointestinal problems
Nausea/vomiting from antibiotics
Arthritis
Artificial joint
Convulsion/epilepsy
Coronary Artery Disease (CAD)
Chronic Obstruction Pulmonary Disease (COPD)
Other_____

Do you have high blood pressure? __ YES __ NO If yes, describe: _____
Have you had any surgical procedures? _____
Have you ever had skin cancer? __ YES __ NO If yes, describe: _____
Has anyone in your family has skin cancer? __ YES __ NO If yes, describe: _____
Has anyone in your family had Melanoma? __ YES __ NO If yes, describe: _____
Do you have a history of any skin diseases? __ YES __ NO If yes, describe: _____
Do you have problems with healing? __ YES __ NO If yes, describe: _____
Do you develop keloid scars after surgery? __ YES __ NO If yes, describe: _____
Do you bleed easily? __ YES __ NO If yes, describe: _____
Do you drink alcohol? __ YES __ NO If yes, how often and how many drinks: _____
Do you use IV drugs? __ YES __ NO If yes, which and how often: _____
Do you smoke? __ Never Smoked __ Former Smoker __Current every day smoker___ Current some days smoker __Heavy tobacco smoker __ Light tobacco smoker
Have you ever been exposed to HIV or AIDS? __ YES __ NO
Are you: __Single __Married __Separated/Divorced __Widowed __GLBT
Women; Are you pregnant? __ YES __ NO Due Date:_____
What is your occupation? _____
What are your hobbies? _____
Have you had sunburns in the past? __ YES __ NO If yes, estimate how many: _____
If you have Diabetes, have you had a foot exam this year? __ YES __ NO
If over the age of 65; Have you had the Pneumococcal Vaccination? __ YES __ NO If yes, when: _____ Month _____ Year If no, why? __ Allergy or Medical reasons __ Declined/other reason

_____ _____

Patient/Parent/Guardian Signature Date