Name_____ Date of Birth_____ Date_____

Reason to be seen:_____
Symptoms: (circle) irritated itch pain bleeding growing changing
How long have you had these problems?_____
Have you seen another doctor for your current skin problem? ___ yes ___ no
Please explain:_____
What did not work?_____
What helped?_____
What medications or other creams do you apply to your skin problems?_____

Please check if you now have or have ever had diseases or conditions of:

__ Blood Disorders
__ Blood Pressure
__ Bones or Joints
__ Breathing (Asthma, Hay Fever etc.)
__ Circulation (Phlebitis etc.)
__ Convulsions
__ Eyes (Glaucoma etc.)
__ Kidneys/Bladder
__ Glands (Thyroid, Diabetes etc.)
__ Hearing
__ Heart (Murmur, Angina etc.)
__ Infections (T.B. etc)
__ Liver (Hepatitis etc.)
__ Mouth
__ Stomach, bowel
__ Have or been exposed to HIV (AIDS)
__ **Artificial body parts (e.g. Heart Valves, Joints)**
__ **Implants (Nerve Stimulators, Parkinson Implant, Cochlear Implant, Deep Brain Stimulators, Pacemaker, or Automatic Defibulator)**

Do you have children? ___ yes ___ no
If so how many? _____
Who do you live with?_____
Do you use tobacco? ___ yes ___ no
If so how often? _____
Do you drink alcohol? ___ yes ___ no
If so how much? _____
Do you use IV drugs? ___yes __no

Do you have or have you had eczema, psoriasis, skin cancer, or other skin problems? ___ yes ___ no
Please explain:_____
Does a relative have eczema, psoriasis, skin cancer or other skin problems? ___ yes ___ no
Please explain:_____
Do you have any **allergies** to medications? ___ yes ___ no
Please explain:_____
Do you take **medications?** ___ yes ___ no Please list: _____
_____
_____
Have you been under a doctor's care or hospitalized in the past five years? ___ yes ___ no
Please explain:_____
When you are exposed to sun do you? ___Burn ___ Tan and Burn ___ Tan only

Do you have unusual reactions to medications or injections (such as fainting)? ___ yes ___ no
Please explain:_____
Do you take antibiotics when you go to the dentist for teeth cleaning? ___ yes ___ no
Please explain:_____
Women only: Are you pregnant, trying to conceive, or breast feeding a child? ___ yes ___ no

Completed by: ___ Patient ___ Medical Assistant

Reviewed by: _____ Date _____