NAME:_____

Who is your primary care physician? _____

What brought you to the office today? (please check appropriate box)

_____Routine skin check
_____Change in Mole
_____Rash
_____Acne
_____Wart
_____Other (Please explain_____
_____
Referred by:_____

LIST ALL MEDICATIONS YOU CURRENTLY TAKE:_____

PERSONAL HISTORY

PLEASE ENCIRCLE ALL ANSWERS

ILLNESSES: Have you ever had:

Chicken Pox	No	Yes
Rheumatic Fever or Heart Disease	No	Yes
Gonorrhea or Syphillis	No	Yes
Jaundice or Hepatitis	No	Yes
Tuberculosis	No	Yes
Frequent infections or boils	No	Yes
AIDS or HIV positive	No	Yes
Anemia	No	Yes
Diabetes	No	Yes
Skin Cancer	No	Yes
Other Cancer	No	Yes
High/low blood pressure	No	Yes
Colitis or other bowel disease	No	Yes
Hay fever or asthma	No	Yes
Hives or Eczema	No	Yes
Arthritis or Rheumatism	No	Yes
Any bone or joint disease	No	Yes
Seizures	No	Yes
Any other disease	No	Yes

OTHER MEDICAL PROBLEMS:
Please List

ALLERGIES: Are you allergic to:

Betadine	No	Yes
Lidocaine	No	Yes
Penicillin	No	Yes
Sulfa	No	Yes
Aspirin, Codeine or Morphine	No	Yes
Mycins or other Antibiotics	No	Yes
Any other drug	No	Yes
Merthiolate or Mercurochrome	No	Yes
Adhesive Tape	No	Yes
Nail Polish or other cosmetics	No	Yes
Tetanus Antitoxinor Serums	No	Yes
Latex	No	Yes
Any foods	No	Yes

TRANSFUSIONS: Have you ever had:

Blood or plasma transfusion	No	Yes

Do you smoke?	No	Yes

if Yes_____Packs Per Day

SURGERY: (Please list)

Type_____Year_____

Type_____Year_____

Type_____Year_____

HAVE YOU EVER FAINTED?	No	Yes

Please explain

DO YOU HAVE ANY OF THESE SYMPTOMS

Brittleness of nails	No	Yes
Dryness of Skin	No	Yes
Easy Bruising	No	Yes
Inability to stand heat	No	Yes
Inability to stand cold	No	Yes
Change in hair texture	No	Yes
Change in skin texture	No	Yes
A skin rash	No	Yes

FAMILY HISTORY

HAS ANY BLOOD RELATIVE EVER HAD:

Skin Cancer	No	Yes
Psoriasis	No	Yes
Eczema	No	Yes
Other skin conditions	No	Yes
Asthma	No	Yes
Hay fever	No	Yes

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Emergency Contact - Please Print

Phone Number

Patient's Signature

Date