

DERMATOLOGY FIRST VISIT

Ref: _____ **INS:** _____

Patient Name _____ Date _____

Reason for visit: _____

Medical Allergies: _____ **Current Medications:** _____

Do you or your family have a history of any of the following?
(Check only those that apply)

Are you currently having problems with any of the following?

	<u>YOU</u>	<u>FAMILY</u>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Dysplastic moles	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (including skin)	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	
Heart Problems	<input type="checkbox"/>	
Lung Problems	<input type="checkbox"/>	
Stomach problems	<input type="checkbox"/>	
Kidney problems	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	
Cosmetic surgery	<input type="checkbox"/>	if yes, when _____

	<u>YES</u>	<u>NO</u>
General Health: (e.g. fever, weight loss)	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/bowels	<input type="checkbox"/>	<input type="checkbox"/>
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>

Social History:

Number of children/age(s) _____ Occupation _____ Hobbies/leisure activities _____

Females: Are you pregnant or planning to become pregnant in the near future? **YES** **NO**

Do you smoke? **YES** **NO** How many packs per day? _____ How many years? _____

How much alcohol do you drink? _____

Reviewed _____ Date _____

(MD signature)