CENTER FOR DERMATOLOGY & LASER SURGERY

Patient Health Form

Patient name: _____ **Date of Birth:** _____
Primary Care Physician: _____ **Referring Physician:** _____
Pharmacy: _____ **Address/Location:** _____

Past Medical History (please circle all that apply):

Anxiety	Hearing Loss
Arthritis	Hepatitis
Artificial heart valve	Hypertension/High Blood Pressure
Artificial joints	HIV/AIDS
Asthma	Hypercholestrolemia/High Cholesterol
Atrial fibrillation	Hyperthyroidism/High Thyroid
BPH (benign prostatic hyperplasia	Hypothyroidism/Low Thyroid
Bone Marrow Transplantation	Leukemia
Breast Cancer	Lung Cancer
Colon Cancer	Lymphoma
COPD (Emphysema	MRSA
Coronary Artery Disease	Prostate Cancer
Depression	Radiation Treatment
Diabetes	Seizures
End Stage Renal Disease	Stroke
GERD (Acid Reflux)	Valve Replacement
	NONE

Other:_____

Past Surgical History (please list):_____
_____
_____

Skin Disease History (please circle all that apply):

Acne	Hay Fever/Allergies
Actinic Keratosis	Melanoma
Asthma	Poison Ivy
Basal Cell Carcinoma	Precancerous (Atypical) Moles
Blistering sunburns	Psoriasis
Dry skin	Squamous Cell Carcinoma
Eczema	NONE
Flaking or itching scalp	

Other: _____

Do you wear Sunscreen? **YES** **NO**
If yes, please list SPF: _____

OVER →

Do you tan in a tanning salon? **YES** **NO**

Do you have a family history of Melanoma? **YES** **NO**

If yes, please list relationship: _____

Do you have a family history of: **Basal Cell Carcinoma** **YES** **NO** **Squamous Cell Carminoma** **YES** **NO**

Polycystic Ovarian Syndrome **YES** **NO** **Autoimmune Disorders** **YES** **NO**

If yes, please list relationship: _____

Current Symptoms (please circle all that apply):

Problems with bleeding
Problems with healing
Problems with scarring
Abdominal pain
Blurry vision
Bloody stool
Joint Aches
Muscle pain/weakness
Depression
Headaches
Dizziness
Shortness of breath
Numbness/Tingling
Irregular menses
Immunosuppression
Cough
Fever or chills
Night sweats
Unintentional weight loss
Thyroid problems
Sore throat
Bloody urine
Neck stiffness
Seizures
Wheezing
Anxiety
Rash
Hay Fever

Alerts (please circle all that apply):

Need antibiotics prior to procedures
Rapid heartbeat with epinephrine
Pregnant or planning a pregnancy Currently
Breastfeeding
Taking blood thinners
Allergy to adhesives
Allergy to Lidocaine (or other injectible numbing)
Allergy to topical antibiotic ointments
Latex allergy
Pacemaker

Please list all medications and supplements you are currently taking:

_____
_____

Please list any drug allergies (ex: antibiotics, aspirin, pain medication, neosporin, etc):

_____
_____

Social History (Please circle one):

Alcohol use:	None	Less than Daily	Daily	1-2 per Day	3 or more per Day
Tobacco use:	Never	Former	Less than Daily	Daily	

Occupation and Workplace: _____

Patient Signature: _____ Date _____