NorCal Dermatology

Medical | Surgical | Cosmetic

NAME_____ **DOB** _____
FIRST MIDDLE LAST

***Reason for your visit today?** _____

How long have you had this problem? _____

Symptoms **(how does it bother you?)**_____

Treatments you have tried? ***(Prescriptions and over the counter)***_____

_____

***CURRENT MEDICATIONS –** include prescriptions and over-the-counter medicines

_____ _____ _____ _____ _____

***ALLERGIES:** to any medications? **[ ] None [ ] IF YES** please list: _____ _____ _____

***MEDICAL AND SKIN HISTORY:** *Check below if you have or ever had any of the following diseases?*

[ ] Artificial heart valves	[ ] Diabetes mellitus 1	[ ] Liver disease	[ ] Acne	[ ] Hives
[ ] Artificial joints	[ ] Diabetes mellitus 2	[ ] Lung disease	[ ] Actinic keratoses	[ ] Itching
[ ] Asthma	[ ] Epilepsy	[ ] Mental/Anxiety disorder	[ ] Alopecia/Hair loss	[ ] Psoriasis
[ ] Bleeding disorder	[ ] Hay fever	[ ] Pacemaker	[ ] Dermatitis	[ ] Rosacea
[ ] Blood clots	[ ] Heart disease	[ ] Seasonal allergies	[ ] Dysplastic mole	[ ] Scabies
[ ] Cancer_____	[ ] Hepatitis A-B-C	[ ] Shingles	[ ] Eczema	[ ] Vitiligo
[ ] Depression	[ ] High Blood Pressure	[ ] Stroke	[ ] Genital Warts	[ ] Warts
[ ] Dementia	[ ] Kidney disease	[ ] Thyroid disease	[ ] Herpes	

PLEASE LIST PAST SURGERIES: _____ _____ _____ _____

SKIN CANCER HISTORY: Have you had **SKIN CANCER?** [ ] Yes [ ] No
If yes, [ ] Melanoma [ ] Basal cell carcinoma [ ] Squamous cell carcinoma [ ] Yes, but don't know type

Locations: _____

FAMILY HISTORY: *Please list any blood relative (**parents, grandparents, siblings, and children**) with a history of*

Skin cancer ***(non-melanoma)*** _____

Melanoma ***(indicate if deceased from melanoma)*** _____

Have you recently had any of the following?

[ ] Allergy symptoms	[ ] Hair loss	[ ] Menstrual problems	[ ] Shortness of breath
[ ] Bleeding problems	[ ] Heat/cold intolerance	[ ] Palpitations	[ ] Swollen lymph node
[ ] Depression	[ ] Joint pain	[ ] Rash	[ ] Weight change

SOCIAL HISTORY
Do you drink alcohol? [ ] Yes [ ] No: If yes, _____drinks/week **DO YOU SMOKE?** [ ] Yes [ ] No: If yes, _____packs/day

OCCUPATION: _____

WOMEN ONLY:
Are you pregnant? [ ] Yes [ ] No Are you breastfeeding? [ ] Yes [ ] No Are you trying to conceive?[ ] Yes [ ] No

***SIGNATURE**_____ **DATE** _____

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