Dermatology Associates at Crystal Run

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Name _____ Date _____

HISTORY

Please describe the reason for your visit today: _____

_____

Have you been to our office before? No Yes *As a patient* *With a Friend* *With a Family Member*

Are you allergic to any medications? No Yes (Please list, and describe what happens when you take this medication)

_____

_____

Are you currently taking any medications? No Yes (Please list)

_____

_____

Are you currently taking any supplements or over-the-counter medications? No Yes (please list)

_____

_____

12 and over. Do you smoke? No Yes Quit

Former Smoker? No Yes

18 years and over. How many times in the past year have you had 5 for men or 4 for women or more drinks in a day? _____

If you are 65 or older, do you have an Advanced Directive (Living Will)? No Yes

If Yes, who is your Proxy? _____

Are you pregnant? No Yes Are you breast feeding? No Yes

Do you have any medical conditions/illnesses? No Yes (Please list)

_____

_____

_____

Have you ever had SKIN cancer? No Yes *What type:* Basal Cell Carcinoma *or* Squamous Cell *or* Melanoma

Have any family members had SKIN cancer ? No Yes *What type:* Basal Cell Carcinoma *or* Squamous Cell *or* Melanoma

Have you ever had any kind of surgery? No Yes (Please list)

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Who referred you to our office? _____

Is it ok to call you at work? No Yes Is it ok to call cell#? No Yes

Is it ok to leave a message on your answering machine or voicemail? No Yes

Is it ok to speak with another person regarding your SKIN condition? No Yes

If Yes, please list names _____

_____