ALLEN DERMATOLOGY & SKIN CANCER CENTER

Name: _____ Date of Birth: _____

(Circle Each that Apply)

Medical conditions that you currently have:

Anxiety

Arthritis

Asthma

Atrial Fibrillation (Irregular Heart Beat)

BPH (Benign Prostatic Hypertrophy)

Bone Marrow Transplantation

Any Organ Transplantation

Breast Cancer

Colon Cancer

COPD

Coronary Artery Disease

Depression

Diabetes

Renal Disease

GERD (Gastro-esophageal Reflux)

Hearing Loss

Hepatitis

Hypertension

HIV/AIDS

Hypercholesterolemia

Hyperthyroidism

Hypothyroidism

Leukemia

Lung Cancer

Lymphoma

Prostate Cancer

Radiation Treatment

Seizures

Stroke

Other

Past Surgical History:

Appendix (Appendectomy)

Bladder (Cystectomy)

Breast

Colon

Gallbladder

Heart

Joint Replacement

Kidney

Ovaries

Prostate

Skin

Spleen

Testicles

Uterus

Other

Social History:

Do you smoke?

Yes / No

Do you drink alcohol?

Yes / No

Married? Single? Other?

Do you have children?

Yes / No

Do you have pets?

Yes / No

Occupation:

_____

Skin Disease History

Acne

Actinic Keratosis

Asthma

Basal Cell Skin Cancer

Blistering Sunburns

Dry Skin

Eczema

Flaking or Itchy Scalp

Hay Fever / Allergies

Herpes Simplex (Fever Blister)

Herpes Zoster (Shingles)

Melanoma

Poison Ivy

Precancerous Moles

Psoriasis

Squamous Cell Carcinoma

Do you wear sunscreen?

Yes / No

If yes, what SPF

_____

Do you tan in the tanning salon? Yes / No

Do you have a family history of melanoma?

Yes / No

If yes, which relative?

_____

Do you have a family history of non-melanoma skin cancer?

Yes / No

ALLEN DERMATOLOGY & SKIN CANCER CENTER

Name: _____ **Date of Birth:** _____

IMPORTANT INFORMATION:

(Circle each one that applies)

Allergy to adhesive
Allergy to lidocaine
Allergy to topical antibiotic ointments
Artificial heart valve
Artificial joints within past two years
Blood thinners
Defibrillator
MRSA
Pacemaker
Premedication prior to procedures
Rapid heart beat with epinephrine
Pregnancy or planning a pregnancy

List allergies – medications, environmental and food

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List medications that you currently take:

(Including over the counter medications, hormones and vitamins)

_____
_____
_____
_____
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ALLEN DERMATOLOGY & SKIN CANCER CENTER

Name: _____ Date of birth: _____

IMPORTANT INFORMATION:
(Circle all that apply to you)

Problems with bleeding

Problems with healing

Problems with scarring (hypertrophic or keloid)

Rash

Immunosuppression

Hay Fever

Chest pain

Fever or chills

Night sweats

Unintentional weight loss

Thyroid problems

Sore throat

Blurry vision

Abdominal pain

Bloody stool

Bloody urine

Joint aches

Muscle weakness

Neck stiffness

Headaches

Seizures

Cough

Shortness of breath

Wheezing

Anxiety

Depression

Dizziness

Diarrhea

Constipation

Nausea

Muscle aches

Somnulence

Changes in a mole or any skin lesion

Hormonal changes

Enlarged lymph nodes

Dry eyes

Conjunctivitis

Other:

_____

_____

_____