BELLAIRE DERMATOLOGY

NAME: _____ OCCUPATION: _____ PREFERRED NAME: _____
AGE: _____
REFERRED BY: _____ HOBBIES: _____

GENERAL MEDICAL HISTORY: Do you have or have you ever had any of the following?

Y	N		Y	N		Y	N	
☐	☐	ANXIETY/DEPRESSION	☐	☐	GERD	☐	☐	PACEMAKER/DEFIB
☐	☐	ARTHRITIS	☐	☐	HEARING LOSS	☐	☐	RADIATION TREATMENT
☐	☐	ASTHMA	☐	☐	HEPATITIS A B C	☐	☐	SEIZURES
☐	☐	ATRIAL FIBRILLATION	☐	☐	HEART DISEASE/ARRYTHEMIA	☐	☐	STROKE
☐	☐	ANEMIA	☐	☐	HIV/AIDS	☐	☐	THYROID DISEASE
☐	☐	AUTOIMMUNE COND TYPE_____	☐	☐	HIGH CHOLESTEROL	OTHER:_____		
☐	☐	BONE MARROW/ORGAN TRANS	☐	☐	HIGH BLOOD PRESSURE	_____		
☐	☐	CANCER/TYPE_____	☐	☐	KIDNEY DISEASE			
☐	☐	COPD/EMPHYSEMA	☐	☐	LUPUS	_____		
☐	☐	DIABETES	☐	☐	MIGRAINES			

SURGERIES:

Y	N		Y	N		Y	N	
☐	☐	APPENDIX	☐	☐	HYSTERECTOMY/TUBAL LIGATION	☐	☐	SPLEEN
☐	☐	BLADDER	☐	☐	JOINT REPLACEMENT TYPE_____	☐	☐	TRANSPLANT SURGERY
☐	☐	BREAST RECONS: R L B	☐	☐	MASECTOMY/LUMPECTOMY R L B	☐	☐	VALVE REPLACEMENT
☐	☐	DENTAL IN LAST 6 MONTHS	☐	☐	MELANOMA	OTHER:_____		
☐	☐	GALLBLADDER	☐	☐	PROSTATE			
☐	☐	HEART SURGERY/STENT	☐	☐	PROSTATE BIOPSY/CANCER	_____		
						_____		

SKIN TYPE:

If exposed to the sun in the summer without sunscreen, would you: 1. always burn, never tan; 2. always burn, sometimes tan; 3. sometimes burn, always tan gradually; 4. burn minimally, always tan well; 5. rarely burn, tan profusely; 6. never burn, deeply pigmented.

☐ ☐	ACNE	☐ ☐	ECZEMA	☐ ☐	KELOID
☐ ☐	ACTINIC KERATOSIS	☐ ☐	FLAKING OR ITCHY SKIN	☐ ☐	**MELANOMA**
☐ ☐	BASAL CELL CANCER/SCC	☐ ☐	HAY FEVER/ALLERGIES	☐ ☐	PRECANCEROUS MOLES
☐ ☐	BLISTERING SUNBURNS	☐ ☐	HSV	☐ ☐	PSORIASIS

OTHER:_____

SKIN CANCER LOCATION: _____ TYPE: _____ TREATED BY: _____
Do you wear sunscreen? ☐/☐ If yes, what SPF? _____
Did you tan in tanning salons? ☐/☐

FAMILY HISTORY: Select any conditions affecting a blood relative and specify who is affected below.
Melanoma ☐ Basal cell or squamous cell skin cancer ☐ Psoriasis ☐ Eczema ☐ Hay fever / allergies ☐ Asthma ☐ Acne ☐
Which relative(s)?
_____
Any other family history?
_____
Are you pregnant or breastfeeding? ☐/☐ If no, method of birth control: _____ Are you contemplating pregnancy? ☐/☐
Yeast infections when taking antibiotics? Y / N ☐ / ☐
Allergies to medications and type of reaction: _____
Medications (Prescription, Non-Prescription, Vitamins): _____
_____

SOCIAL HISTORY: Please circle all that apply.

MARITAL STATUS	Single ☐ Married ☐ Divorce ☐ Widow ☐
CIGARETTE SMOKING	Never smoked ☐ Quit (former smoker) ☐ Smokes less than daily ☐ Smokes daily ☐
ILLICIT DRUG USE	None ☐ Drug Use ☐ IV drug use ☐
ALCOHOL USE	None ☐ Less than 1 drink a day ☐ 1-2 drinks a day ☐ 3 or more drinks a day ☐
SAFETY	I feel safe at home ☐ I do not feel safe at home ☐
BLOOD THINNER	☐ ☐
ASPIRIN	☐ ☐
RECENT VACCINATIONS:	_____