



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

SURGERIES:

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

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

OTHER: _____

SKIN CANCER LOCATION: _____ TYPE: _____ TREATED BY: _____

Do you wear sunscreen? Y / N If yes, what SPF? _____

Did you tan in tanning salons? Y / N

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? Y / N If no, method of birth control: _____ Are you contemplating pregnancy? Y / N
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	Y	N		
ASPIRIN	Y	N		

RECENT VACCINATIONS: _____