Name _____ DOB: _____

Phone # ( ) _____ Primary Care Physician: _____

What is the reason for today's visit? _____

HISTORY OF PRESENT ILLNESS

If you are here to have moles checked:

Are there any particular growths you are concerned about? _____

How long have they been there? _____

Where are they located? _____

Has there been any change? _____

Any bleeding or irritation? _____

If you are here for a skin rash, acne, eczema, psoriasis or other problems of the skin, hair or nails:

How long has it been a problem? _____

Have you tried any over the counter or prescription medications? _____

What has helped? _____

Any side effects? _____

Any associated symptoms like itch or pain? _____

List all medications including birth control and over the counter medications and supplements: _____

_____

_____

List any allergies to medications: _____

Do you have a history of excessive sun exposure? _____

When exposed to the sun, do you burn only, burn then tan, or tan? _____

Do you have a history of blistering sunburns? _____

Are you pregnant or nursing? _____

Any recent health changes? _____

Do you have any of the following symptoms? Y for Yes, N for No:

Weight loss ____	Fever ____	Fatigue ____	Depressed Mood ____	Breathing Difficulties ____
Chest Pain ____	Palpitations ____	Easy bruising or bleeding _____		Stomach problems ____
Headaches ____	Arthritis ____	Change in menstrual periods? _____		Fainting or seizures ____

Past Medical History

Do you have a history of skin cancer? Yes ____ No _____

Do you have a history of the following conditions? Basal Cell _____ Squamous cell _____ Melanoma _____ Asthma _____

High blood pressure _____ Chest Pain ____ Heart valve _____ Pacemaker _____ Heart Attack _____ High Cholesterol _____

Irregular or fast heartbeat _____ Fainting _____ Blood Clots _____ Glaucoma ____ Diabetes ____ Thyroid Disease _____

Kidney or bladder problems _____ Liver problems _____

FAMILY HISTORY: Family history of skin cancer? _____ Multiple moles? _____ Melanoma _____

Family History of other skin disease? _____

SOCIAL HISTORY: What is your occupation? _____

Do you smoke? _____ How much? _____ Do you drink alcohol? _____ How much? _____