TRIANGLE DERMATOLOGY ASSOCIATES

_______________________ _______________________ _______________________
FIRST MIDDLE LAST

WHAT IS THE REASON FOR YOUR VISIT TODAY? ___________________

Location on body: ___________________
How long has this been going on? ___________________
What symptoms are you having (itching, bleeding, pain)? ___________________
Does anything make your problem better or worse? ___________________
What treatments are you using now? ___________________
What treatments have you used in the past? ___________________

If time allows, what other skin related problem would you like to discuss with the doctor? ___________________

MEDICATIONS: (Please list all current prescription medications, over-the-counter medications, and supplements.)

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Pharmacy of choice: ___________________

MEDICATION ALLERGIES: ___________________

Are you allergic to: ❏ Y ❏ N Latex ❏ Y ❏ N Adhesive tape

CURRENT AND PAST MEDICAL CONDITIONS: ❏ No past medical history

❏ Y ❏ N Asthma
❏ Y ❏ N Bleeding disorder
❏ Y ❏ N Cancer (other than skin)
❏ Y ❏ N Diabetes
❏ Y ❏ N Eczema
❏ Y ❏ N Fainting reaction
❏ Y ❏ N Heart valve or heart problems
❏ Y ❏ N Hepatitis (if so Type __)
❏ Y ❏ N Herpes/cold sores/fever blisters
❏ Y ❏ N High blood pressure
❏ Y ❏ N Infections
❏ Y ❏ N Kidney problems
❏ Y ❏ N Malignant melanoma
❏ Y ❏ N Psoriasis
❏ Y ❏ N Radiation treatments
❏ Y ❏ N Seizures
❏ Y ❏ N Skin cancer
❏ Y ❏ N Skin disease
❏ Y ❏ N Stroke
❏ Y ❏ N Thyroid disorder
❏ Y ❏ N Unusual moles

Other, please list: ___________________
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PAST SURGERIES AND HOSPITALIZATIONS:

Please list all surgeries, including skin cancer surgery and approximate dates: ___________________
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Do you have: ❏ Y ❏ N Artificial joints ❏ Y ❏ N Heart valve replacement ❏ Y ❏ N A pacemaker/defibrillator implant
Do you take oral antibiotics before having surgical procedures or dental work? ❏ Y ❏ N

FAMILY MEDICAL HISTORY: (If yes, please list how the family member is related to you.)

❏ Y ❏ N Abnormal bleeding
❏ Y ❏ N Asthma
❏ Y ❏ N Autoimmune disorders
❏ Y ❏ N Eczema
❏ Y ❏ N Lupus
❏ Y ❏ N Melanoma
❏ Y ❏ N Non-melanoma skin cancer
❏ Y ❏ N Psoriasis
❏ Y ❏ N Skin disease
❏ Y ❏ N Thyroid disease

SOCIAL HISTORY:

Do you drink alcohol? ❏ Y ❏ N
Do you smoke? ❏ Y ❏ N
Do you use a tanning bed? ❏ Y ❏ N
Do you use recreational drugs? ❏ Y ❏ N
Did you have blistering sunburns as a child? ❏ Y ❏ N
When was the last time you got a sunburn? ___________________

ARE YOU HAVING ANY OF THE FOLLOWING?

❏ Y ❏ N Chills
❏ Y ❏ N Cold Intolerance
❏ Y ❏ N Fever
❏ Y ❏ N Heat intolerance
❏ Y ❏ N Nausea
❏ Y ❏ N Unintentional weight loss

Females only:
Are you currently pregnant or considering becoming pregnant? ❏ Y ❏ N Are you currently breastfeeding? ❏ Y ❏ N