

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.)

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

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

Other, please list: _____

Females only:

Are you currently pregnant or considering becoming pregnant? Y N Are you currently breastfeeding? Y N

PAST SURGERIES AND HOSPITALIZATIONS:

Please list all surgeries, including skin cancer surgery and approximate dates: _____

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.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus | <input type="checkbox"/> Y <input type="checkbox"/> N Psoriasis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Melanoma | <input type="checkbox"/> Y <input type="checkbox"/> N Skin disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune disorders | <input type="checkbox"/> Y <input type="checkbox"/> N Non-melanoma skin cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Eczema | | |

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 Fever

Y N Nausea

Y N Cold Intolerance

Y N Heat intolerance

Y N Unintentional weight loss