THE DERMATOLOGY SPECIALISTS

Skincare Intake / Medical History Form

PATIENT NAME_____ **DATE:**_____/_____/_____

MEDICAL HISTORY

Please describe your primary reason for visiting dermatologist today: _____
_____

*Are you currently taking any medications? If yes, please list:*_____
_____

Have you been having any systemic symptoms you'd like the doctor to know about? (PLEASE CIRCLE)
ENT ALLERGY CARDIOLOGY MUSCULOSKELETAL RESPIRATORY PSYCHOLOGY HEMATOLOGY

NEUROLOGY GASTROENTEROLOGY UROLOGY OTHER_____

EXPLAIN SYMPTOMS: _____

*List any allergies you may have to(specifically to MEDICINE)*_____

Have you ever been hospitalized? If yes, please list the date and reason/procedure:_____

*Have you had any surgical procedures performed? If yes, please list the date and procedure:*_____
_____

FAMILY HISTORY

Relative:	*Status:*	*Date of Birth:*
Father:	Alive___ Deceased___	____/____/____
Mother:	Alive___ Deceased___	____/____/____
Siblings:	Alive___ Deceased___	____/____/____
Children:	Alive___ Deceased___	____/____/____

SOCIAL HISTORY

Social Information:	Options:	Addtl' Notes:
Smoking?	Y___ N____	_____
Smoking in household?	Y___ N____	_____
Familial Alcohol use?	Y___ N____	_____
Recreational drug use?	Y___ N____	_____
Do you use sunscreen?	Y___ N____	_____
Had a blistering sunburn?	Y___ N____	_____
Been exposed to HIV?	Y___ N____	_____
Exposed to HEP A,B,C,D?	Y___ N____	_____

Any loss of appetite, weakness or night sweats? Y___ N____ _____

STATISTICS

What is your approximate height in feet/inches?_____
What is your approximate weight in pounds?_____