INTEGRATED
DERMATOLOGY

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Patient Registration & Health History

Date: _____________

Name: ____ **DOB:** _______**Sex: M/F SSN:**____-___-_____

Address:______________________________________**City:**____________**State:**__________**Zip**__________

Telephone Number

Home________________**Cell**_____________________**Work**______________________

Referred By: ____

Primary Care Physician: Dr.___________________________________ **Phone:** ________________________

Reason for Visit (One or Two Main Problems to Address Today): ____________________________________

____

Duration of Problem: ____

Treatment: ____

Aggravating factors: ____

Current Medications (please include OTC, herbs, vitamins, supplements): ______________________________

____

____

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Allergies to Medication: ☐**None** ☐**Other**

____

Other Allergies: ☐**None** ☐**Latex** ☐**Bandages/Adhesive**

☐**Topical Antibiotic (Neosporin or other)**

____

Have you ever had any bad reaction to local anesthesia? ☐**No** ☐**Yes**

☐**Never had anesthesia**

PAST Medical History:____

____

PAST Surgeries (Type and Date):

____

____

FAMILY HISTORY: ☐ **Eczema** ☐ **Psoriasis** ☐**Melanoma**

☐**Other**___________________________

SOCIAL HISTORY:

Marital Status: ☐**Single** ☐**Married** ☐**Divorced** ☐**Widow/Widower**

Occupation:

____

Smoking: ☐**No** ☐**Former** ☐**Yes, packs/day**

____

Alcohol: ☐**No** ☐**Yes, how much/often**

____

Flu Shot: **No** **Yes**

Pneumonia Vaccine: **No** **Yes**

FOR WOMEN ONLY:

Are you currently pregnant, trying to become pregnant, or are you nursing?

____

Are you on a contraceptive, if so what form?

____

SKIN CONDITIONS:

Have you ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer

☐Melanoma

Where? ____________________________________When?

____

Treatment? ____

Has anyone if your family ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Who? ____

Do you have a history of any skin problems or diseases? ☐No ☐Yes

If Yes, ☐Psoriasis ☐Eczema ☐Keloid ☐Other

____

SUN EXPOSURE:

When you are exposed to the sun do you:

☐ always burn ☐ rarely burn, always tan well

☐ usually burn, tan minimally ☐ very rarely burn, tan very easily

☐ sometimes mild burn, tan uniformly ☐ never burn, tan very easily

Did you have: ☐ sunburns every summer in childhood

☐ at least one blistering sunburn, how many ___________

☐ ever use a tanning bed, how many times/how often ____________

☐ regular sunscreen use, SPF _____________

REVIEW OF SYSTEMS: Please check if you are experiencing of the following today.

ENT: ☐Headaches ☐Vertigo ☐Vision Changes

Constitutional: ☐Weight gain ☐Weight loss ☐Fevers ☐Night sweats

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Cardiovascular: ☐Palpitations ☐Artificial Heart Valve ☐Pacemaker ☐Chest Pain

☐Other ____

Endocrine: ☐Excessive Sweating ☐Irregular Menses ☐Abnormal Hair Growth ☐Polycystic Ovarian Disease

Gastrointestinal: ☐Diarrhea ☐Constipation ☐Nausea

☐Other ____

Genital/Urinary: ☐Pain w/ urination ☐Ulcers in genital area ☐Urinary Discharge

Integumentary: ☐Rash ☐Acne ☐Dry Skin ☐New Growth ☐ Hair loss

☐Other ____

Musculoskeletal: ☐Muscle weakness ☐Restless Leg Syndrome ☐Joint Pain

Neurological: ☐Stroke ☐Seizures/Epilepsy ☐Multiple Sclerosis

☐Other ____

Respiratory: ☐Shortness of breath ☐Cough ☐Wheezing

Others: ☐Kidney Problems ☐Cold Sores ☐Varicose Veins

☐Require Antibiotics Prior to Dentistry

☐Denies All

By signing, I am acknowledging that I have disclosed all my health information known to me at this time, and all my other personal information is accurate. I understand that it is my obligation and responsibility to notify Integrated Dermatology of North Raleigh of any changes to my medical history so I may receive proper treatment.

❖ **SIGNATURE**______________________________ **Date** ________________

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