INTEGRATED DERMATOLOGY OF TIDEWATER

Patient Name _____ Date: _____

Patient Date of Birth _____ Person Completing Form: _____

Patient History

Do you currently, or have you in the past, had problems with any of the following? (Check all that apply.)

____Antibiotics prior to Dentistry
____Artificial Joints/Heart Valves
____Diabetes
____Glaucoma
____Hepatitis
____HIV/AIDS
____Immunosuppressed
____ Melanoma or non melanoma skin cancer
____Stroke
____Pacemaker
____Pregnancy
____Lupus
____Breast Cancer
____Sarcoidosis
____History of Lung Cancer
____Anxiety
____History of Renal Cancer
____Hypothyroid
____CHF

Patient System History

____Bleeding Problems
____Allergic or Immunologic
____Respiratory Difficulites
____Cardiovascular Problems
____Ear, Nose, Throat Problems
____Eye Problems
____Fever or Chills
____Genital/Urinary Problems
____GI Problems
____GU Problems
____Skin Problems
____Joint or Musculoskeletal
____Nausea, Fever, Diarrhea
____Neurological Problems
____Psychiatric Difficulties

Dermatological History

____Form Keloids
____Any Cancer
____Melanoma
____Psoriasis
____Sun Burns
____Squamous Cell
____Basal Cell
____Atypia

Allergies (list all; including allergies to medicine)

_____ _____
_____ _____
_____ _____
_____ _____

Medications Currently Taking

_____ _____
_____ _____
_____ _____
_____ _____
_____ Continue List on Back

Social History

Do You Use Alcohol? ___Yes ___No
At Least 1 Blistering Sunburn ___Yes ___No
Do You Use Recreational Drugs? ___Yes ___No
Do You Use Sunscreen? ___Yes ___No
Profession _____

Family Medical History-Check box if YES

Your Weight _____
Your Height _____

	Your Father	*Your Mother*	*Siblings 1*	*Siblings 2*	*Children 1*	*Children 2*	*Grandparent*
Abnormal Moles							
Allergies							
Any Cancer							
Eczema							
Malignant Melanoma							
Non Melanoma Skin Cancer							
Psoriasis							