

Patient Name _____ D.O.B. _____ Date _____

Allergies none, or _____

Current Medications none, or _____

Pharmacy _____ Town, State _____ Street _____ Pharmacy Phone _____

Primary Care Physician _____ Who recommended this visit? _____

Reason for today's visit _____ When did the problem begin? _____

Which areas are involved? _____

Please check all that apply: Itchy Painful Bleeding Getting Better Getting Worse

What treatments were tried? _____ Did the treatments help? _____

Would you like a skin check/total body screening examination today (time permitting)? yes no

Current medical problems none, or _____

Past medical problems or surgeries

My health

- Fevers
- Headaches
- Joint Pain
- Bleeding Problems
- Pregnancy
- Planning pregnancy
- Anxiety
- Depression
- Other mental health concerns

My skin history

- Psoriasis
- Eczema
- Acne
- Atypical moles/dysplastic nevi
- Multiple sunburns
- History of blistering sunburn(s)
- Skin cancer Type if known _____

Please check all that apply

Family skin history

- Psoriasis
- Eczema
- Acne
- Melanoma
- Atypical moles/dysplastic nevi
- Skin Cancer
- Who _____

About me

Live alone yes no If no, who lives with you? _____

Occupation (including caregiver, homemaker): _____

Hobbies/leisure activities _____

My habits

Do you wear sunblock? yes no

Daily When at the beach SPF _____

Ever used a tanning booth? yes no

Number of times (approx.) _____

Do you drink alcohol? yes no

Drinks per week _____

Do you smoke? yes no

