Dermatology and Skin Care ASSOCIATES, P.C.

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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

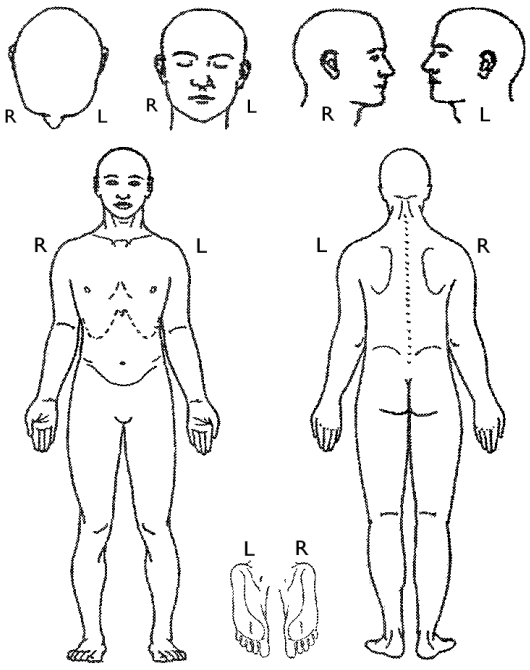
☐ Psoriasis
☐ Eczema
☐ Acne
☐ Melanoma
☐ Atypical moles/ dysplastic nevi
☐ Skin Cancer
Who _____

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