DermSpecialists
A Forefront Dermatology Practice

Patient Name: ____________________________ **Primary Doctor:** ___________________________

Date of Birth: ______________________________ **Pharmacy:** _______________________________

Reason for Visit: ____

Please check one:

Tobacco user:
- ☐ Current
- ☐ Former
- ☐ Never

Alcohol use:
- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Socially
- ☐ Never

History of Tanning Bed Use:
- ☐ Yes
- ☐ No

Medical History: (Please check all that apply)
- ☐ Actinic Keratosis
- ☐ Allergies
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots
- ☐ Communicable Diseases: __________
- ☐ Cancers Type: _________________
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Gastrointestinal Disease
- ☐ Other: ________________
- ☐ Glaucoma
- ☐ Hepatitis C
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Multiple Sclerosis
- ☐ Phlebitis
- ☐ Psoriasis
- ☐ Renal Disease
- ☐ Rosacea
- ☐ Seizure Disorder
- ☐ Thyroid Disease
- ☐ Tuberculosis

Surgical History: (Please check all that apply)
- ☐ Defibrillator Year: ___________________
- ☐ Organ Transplant Type: _______ Year: ______
- ☐ Pacemaker Year: ___________________
- ☐ Other: _____________ Year: ___________________

Skin Cancer History: (Please check all that apply)
- ☐ Basal Cell
  Year & location: ________________________
- ☐ Squamous Cell
  Year & location: ________________________
- ☐ Melanoma
  Year & location: ________________________

Family medical history: (please check all that apply for mother, father, siblings & extended family)
- ☐ Basal Cell
- ☐ Squamous Cell
- ☐ Melanoma
- ☐ Eczema
- ☐ Psoriasis
- ☐ Dermatitis

List of current medications: (Prescription, over the counter and as needed)

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List of Drug Allergies:

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