

Name _____

Date ___/___/___

Reason for visit	Location	How long has it lasted ?	Any symptoms? itch / pain	Any medications or treatments help?
1.				
2.				

List all medications / herbs / over the counter: - we can photocopy your list

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

Medication allergies (describe reaction)? _____

Do you have now, or have you ever had any of the following diseases ?

	Yes	No		Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (type) _____			Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers / Reflux	<input type="checkbox"/>	<input type="checkbox"/>

Other conditions: 1. _____ 2. _____

Do you have any of the following symptoms ?

	Yes	No		Yes	No
Allergy to tape	<input type="checkbox"/>	<input type="checkbox"/>	Dry skin	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	Problems healing	<input type="checkbox"/>	<input type="checkbox"/>
Depression / anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Scar easily	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	Vision changes	<input type="checkbox"/>	<input type="checkbox"/>

Surgical / Dermatology History: (Please check)

YES NO

Have you ever had eye surgery ?		
Have you had atypical / dysplastic moles ?		
Have you had melanoma skin cancer ?		
Have you had skin cancer? If so, circle which type it was. 1) Basal cell 2) Squamous Cell 3) Can't recall		
Has anyone in your family had skin cancer?		

Social History: (Please check)

YES

NO

If YES, how much?

Do you drink alcohol ?			
(Woman) Are you pregnant ?			
Do you smoke?			
Do you use sunscreen?			