neda SKIN SOLUTIONS | NORTHEAST DERMATOLOGY ASSOCIATES

Today's Date: _____/_____/_____

Please complete each section and both sides of this sheet

PERSONAL INFORMATION

Patient Name: _____ Patient date of birth: _____/_____/_____

Pharmacy Name and Address: _____

Primary Care Physician: _____

Can we leave a message with detailed clinical information (such as a test result) on the telephone number(s) you have provided us? □ Yes □ No

Please provide name, relation to you, and phone number of anyone you consent us to share your personal health information with:

_____

What is your preferred language? □ English □ Other: _____

MEDICATIONS *Please list with dosages. Include contraceptives. Attach list if needed.* □ **None**

Do we have your permission to electronically request the medications you take from your pharmacy/insurance company? □ Yes □ No Please still list your medications below, as sometimes we are unable to digitally import.

_____ _____

_____ _____

_____ _____

_____ _____

DRUG ALLERGIES *List allergies to medications and medical products and the type of reaction you had.* □ **None**

reaction types include: anaphylaxis, angioedema (facial swelling), diarrhea, fatigue, GI upset, hives, rash, liver toxicity

_____ _____

_____ _____

_____ _____

Are you allergic to Latex? □ Yes □ No Are you allergic to adhesive? □ Yes □ No

HABITS AND ACTIVITIES

Do you wear sunscreen? □ Yes □ No If yes, what SPF? _____

Do you tan in a tanning salon? □ Yes □ No

Do you have a family history of Malignant Melanoma? □ Yes □ No If yes, what relative(s)? _____

Do you smoke tobacco? □ Yes □ Never Smoker □ Former smoker

Please answer if age 65 years or older:

Do you have a health care proxy? □ Yes □ No

REVIEW OF SYSTEMS Please check all of the following that you have. □ **None**

□ Problems with bleeding
□ Problems with scarring (hypertrophic or keloid)
□ Changing mole
□ Cough
□ Fever or chills
□ Hay fever
□ Shortness of breath
□ Thyroid problems

SKIN CONDITIONS Please check all of the following that you have had in the past. □ **None**

□ Acne
□ Actinic keratoses
□ Basal cell skin cancer
□ Poison ivy reaction
□ Dry skin
□ Precancerous moles
□ Eczema
□ Hay Fever
□ Melanoma
□ Flaking or itchy scalp
□ Psoriasis
□ Squamous cell skin cancer
□ Blistering sunburns
□ Other: _____

If you have a current diagnosis of Psoriasis, what Medication are you using to treat it? _____

MEDICAL CONDITIONS Please check all of the following that you have. □ **None**

□ Anxiety
□ Arthritis
□ Asthma
□ Atrial Fibrillation (irregular heartbeat)
□ Coronary Artery Disease
□ Depression
□ Diabetes
□ End Stage Renal Disease
□ Hearing Loss
□ Hepatitis
□ Hypertension
□ HIV/AIDS
□ Hypercholesterolemia (high cholesterol)
□ Hyperthyroidism
□ Hypothyroidism
□ Leukemia
□ Lung Cancer
□ Lymphoma
□ Prostate Cancer
□ Radiation therapy
□ Seizures
□ Stroke
□ Other: _____

SURGICAL HISTORY Please check all of the following that you have. □ **None**

□ Appendix: appendectomy
□ Bladder: cystectomy
□ Breast: cancer, lumpectomy, or mastectomy
□ Colon: colectomy
□ Gallbladder: cholecystectomy
□ Heart: coronary artery bypass surgery
□ Heart: PTCA
□ Heart: mechanical valve replacement
□ Heart: biological valve replacement
□ Heart: heart transplant
□ Skin: skin biopsy
□ Skin: basal cell carcinoma
□ Skin: squamous cell carcinoma
□ Skin: melanoma
□ Spleen: splenectomy
□ Uterus: hysterectomy
□ Uterus: tubal ligation
□ Other: _____

MEDICAL ALERTS Please check all of the following statements that apply to you. □ **None**

□ Have MVP (Mitral Valve Prolapse)
□ Have a pacemaker
□ Have a defibrillator
□ Have an artificial heart valve
□ Pre-medicate prior to procedures
□ Have an allergy to adhesive
□ Have an allergy to topical antibiotic ointments
□ Take blood thinners (i.e. aspirin, Coumadin, etc.)
□ Allergic to lidocaine
□ Get rapid heartbeat with epinephrine
□ Get yeast infection with antibiotics
□ Have GI upset with antibiotics