Date of Appointment: _____

Trident Dermatology

PATIENT HISTORY (REV 1/17)

Patient's Name: _____ DOB: _____ Age: _____ Sex: M / F

Did a physician refer you to us? Y / N If yes, what is his/her name? _____

Who is your primary care provider? _____

Past Medical History:

- Have you had an **Artificial Joint procedure within the last 2 years?** **Yes No**
- Have you **EVER** had an **Artificial Valve Replacement?** **Yes No**
- **Do you have a Defibrillator?** **Yes No**
- **Do you have a Pacemaker?** **Yes No**

☐ Anxiety	☐ Arthritis	☐ Asthma	☐ Atrial Fibrillation
☐ Bone Marrow Transplant	☐ BPH	☐ Breast Cancer	☐ Colon Cancer
☐ COPD	☐ Coronary Artery Disease	☐ Depression	☐ Diabetes
☐ Renal Disease	☐ GERD	☐ Hearing Loss	☐ Hepatitis
☐ HIV/AIDS	☐ High Cholesterol	☐ High Blood Pressure	☐ Hyperthyroid
☐ Hypothyroid	☐ Leukemia	☐ Lung Cancer	☐ Lymphoma
☐ Prostate Cancer	☐ Radiation Treatment	☐ Seizures	☐ Stroke
☐ Other:			

Have you had a complete skin exam before? Yes No

If yes, when was your last exam?_____

Would you like a full skin exam today? (head-to-toe examination of your skin) Yes No

Do you have any kidney or liver problems that could affect medications you may be prescribed? Yes No

Do you require antibiotics before surgery or dental procedures? Yes No

Do your scars make unusual thick bumps called keloids? Yes No

Females only:

Are you pregnant? Y / N If yes, _____ months?

Are you planning to become pregnant in the near future? Yes No

Have you had any of the following skin conditions?

☐ None	☐ Acne	☐ Actinic keratosis (pre-cancers)	☐ Basal cell skin cancer
☐ Blistering sunburns	☐ Dry skin	☐ Eczema	☐ Flaking or itchy scalp
☐ Hay fever/Allergies	☐ Melanoma	☐ Poison Ivy	☐ Pre-cancerous moles
☐ Psoriasis	☐ Squamous cell skin cancer	☐ Other:	

Do you wear sunscreen? Y / N If yes, what SPF? _____

Do you tan in a tanning salon? Y / N

Do you have a **Family History** of Melanoma? Y / N If yes, which relative? _____

Do you have a **Family History** of other skin cancers? Y / N If yes, which relative? _____

Surgical History: (Please list all SKIN CANCER surgeries and any other MAJOR surgeries)

1.	2.
3.	4.

Medications: (Please list all meds you are currently taking with the dosage and approximate date started)

Medication	Date Started	Medication	Date Started

*******PLEASE COMPLETE BACK SIDE OF FORM!!!**

Date of Appointment: _____

Trident Dermatology

PATIENT HISTORY (REV 1/17)

What medications are you allergic to? _____

Social History:

Have you ever smoked? Y / N Do you currently smoke? Y / N

Do you drink alcohol? ___None ___<1 drink per day ___1-2 drinks per day ___3-4 drinks per day

Race (please circle): White Black/African American Asian American Indian/Native Alaskan

Preferred Language: English Spanish Other: _____

Please tell us about why you are here today:

(If you have more than 3 complaints, choose the top 3 that are most important to you today. In consideration for others waiting, you may need to schedule another appointment to address additional concerns.)

PROBLEM #1:

What is it? (rash, acne, bumps, skin lesion- growing, painful, bleeding, red, itchy) _____

Where is the problem? (arms, legs, scalp, etc.) _____

How long have you had it? _____

What treatments/medicines have you tried& did they help? _____

What makes it better or worse?(weather changes, picking at it, etc.) _____

PROBLEM #2:

What is it? (rash, acne, bumps, skin lesion- growing, painful, bleeding, red, itchy) _____

Where is the problem? (arms, legs, scalp, etc.) _____

How long have you had it? _____

What treatments/medicines have you tried & did they help? _____

What makes it better or worse?(weather changes, picking at it, etc.) _____

PROBLEM #3:

What is it? (rash, acne, bumps, skin lesion- growing, painful, bleeding, red, itchy) _____

Where is the problem? (arms, legs, scalp, etc.) _____

How long have you had it? _____

What treatments/medicines have you tried & did they help? _____

What makes it better or worse?(weather changes, picking at it, etc.) _____

***Your dermatologist can perform a skin screening for cancer or abnormal moles at your request. Please tell your nurse if you would like a complete skin exam when you are taken into the exam room. ***

Pharmacy _____ Street & City _____

Do we have permission to leave a message on your answering machine? YES NO