Associates in Dermatology, Inc.

Name:_____ Date:_____

Please describe your skin problem/condition: _____

_____

How long have you had this condition? _____

Please list anything you have tried to treat this condition (prescribed or over the counter): _____

_____

Please use the diagram at the bottom of the page to mark where the problem is located.

Do you or any member of your family (parent, siblings, children) have a history of the following:

	Self		Family	
A. Skin Cancer	Yes	No	Yes	No
B. Eczema	Yes	No	Yes	No
C. Psoriasis	Yes	No	Yes	No
D. Lupus	Yes	No	Yes	No
E. Asthma	Yes	No	Yes	No
F. Hay Fever	Yes	No	Yes	No
G. Diabetes	Yes	No	Yes	No
H. Rheumatoid Arthritis	Yes	No	Yes	No

Please list ALL medication you currently take (prescribed or over the counter).

_____

_____

_____

Medication Allergies: Yes No List: _____

Latex Allergies: Yes No

Are you required to take antibiotics prior to dental cleanings or surgical procedures? Yes No

Have you had or do you have any of the following:
heart valve replacement, heart valve dysfunction like mitral valve prolapsed, hip or knee replacement Yes No

Please list any other medical conditions that we should be aware of:

_____

_____

Are you interested in scheduling a full body exam? Yes No

UPDATED:_____

(FOR OFFICE USE ONLY)

_____

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Medication Update:

_____

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Yes No

Yes No

Yes No

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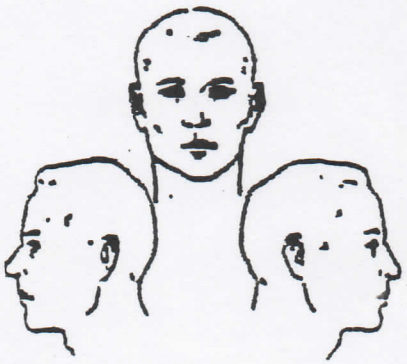
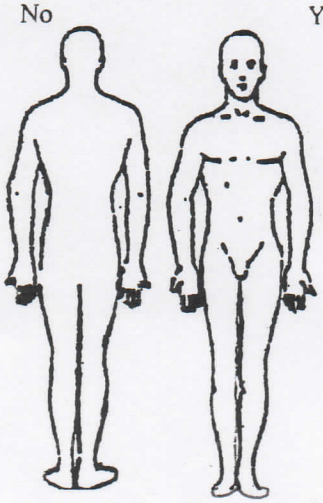
Yes No





Revised 06/10