

Boulevard Dermatology
8001 Roosevelt Blvd Ste 307
Philadelphia, PA 19152

Reason for Visit

What brings you to the office today?

Please describe any previous skin problems you have had.

Allergies

Are you allergic to any of the following?

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Local Anesthetics |

Do you have any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Abnormal Moles | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry / Sensitive Skin | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Boils | <input type="checkbox"/> Eczema | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Bleed Easily | <input type="checkbox"/> Hives | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Changes in Moles | <input type="checkbox"/> Itching | <input type="checkbox"/> Sores That Won't Heal |
| <input type="checkbox"/> Chills | | |

Have you ever had a biopsy for a suspicious growth?

- Yes No

Do you have any other allergies?

Name _____ Reaction _____

When you are exposed to the sun do you:

- Tan Only Tan and Burn Burn Only

Have you visited tanning salons or do you sunbathe?

- Yes No

Do you regularly apply sunblock to exposed areas?

- Yes No If yes, which SPF? _____

Have you ever had skin cancer?

- Yes No If yes, what type? _____

When? _____ Where? _____

Past Medical History

Have you ever had any of the following?

- | | | | | | |
|---|--|---|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Migraines | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Joint Disorder | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Bowel Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disorder | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis - A, B, or C | <input type="checkbox"/> Lupus | <input type="checkbox"/> Skin Disorder | |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke | |

Hospitalizations & Surgeries

Reason _____ Date _____

Reason _____ Date _____

Women Only

Are you pregnant?

- Yes No

Are you breastfeeding?

- Yes No

Lifestyle Factors

Have you ever smoked?

- Yes No # of years _____ # packs/day _____

Do you smoke now?

- Yes No # packs/day _____

Do you use recreational drugs?

- Yes No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

Family History

Has anyone in your family ever had any of the following conditions?

- | | | |
|---|---|--|
| <input type="checkbox"/> Abnormal Moles | <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Cancer | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Asthma | | |

Details: _____
