North Branch Dermatology

Patient Medical Record Information

Patient:_________________________________ **Date**:_______________ **Date of Birth**:___________________

Do you have/had any of the following?

Anxiety		Coronary Heart Disease		High Cholesterol		Seizures	
Arthritis		Depression		Hyperthyroidism		Stroke	
Asthma		Diabetes		Leukemia		Other	
Atrial Fibrillation		End Stage Renal Disease		Lung Cancer			
BPH		GERD		Lymphoma			
Breast Cancer		Hearing Loss		Pregnancy (current/planning)			
Colon Cancer		Hepatitis		Prostate Cancer			
COPD		High Blood Pressure		Radiation Treatment			

Past Surgeries:

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Have YOU had any of the following skin conditions?

Acne		Hay Fever/Allergies		**Sunscreen Use:**
Actinic Keratosis (AK)		Melanoma		- Yes
Basal Cell Skin Cancer (BCC)		Poison Ivy		- No
Blistering Sunburns		Precancerous Moles		What SPF:__________
Dry Skin		Psoriasis		
Eczema		Squamous Cell Skin Cancer (SCC)		
Flaking or Itchy Scalp		Tanning Bed Exposure:		

Family History of Skin Cancer?

Yes:____________ (which family member)_____________ No:__________

Basal Cell:________ Squamous Cell:___________ Melanoma:_____________ None:____________

Current Medications?

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Allergies:

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Occupation and Workplace:____

Smoking Status:

Never Smoker	
Current Smoker:	
- How many packs per day	
- Total years smoking	
Other: (Former)	

Alcohol Use:

Never	
Less than 1 drink per day	
1-2 drinks per day	
3 or more drinks per day	
IV drug user	

Please circle any of the following symptoms that you are CURRENTLY experiencing:

Problems with bleeding	Unintentional weight loss/gain	Neck Stiffness
Problems with healing	Thyroid problems	Headaches
Problems with scarring	Sore throat	Seizures
Rash	Blurry vision	Cough
Immunosuppression	Abdominal pain	Shortness of breath
Hay Fever	Bloody stool	Wheezing
Chest Pain	Bloody urine	Anxiety
Fever or chills	Joint aches	Depression
Night sweats	Muscle weakness	Other:

*****ALERTS:*****

Do you require *pre-medication* (i.e. antibiotics, anxiety medications) prior to procedure? ___Yes ___No

Do you have a *pacemaker*? ___Yes ___ No

Do you have a *defibrillator*? ___Yes ___No

Is there anything else we should be aware of before treating you?

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Any interest in cosmetic treatments?

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