Name:_____ Age:_____ Date:_____

Reason for today's visit:

_____

_____

Please list all skin problems and creams/pills taken:

_____

_____

Please list all previous skin surgeries and diagnosis:

_____

Do you see any doctor for any other problems? Please list:

_____

_____

_____

Do you have any medicine allergies? No_____ Yes_____ Please list:

_____

Please list all medications you take for any medical condition including nonpresccription, vitamins, herbs, birth control pills, etc.

_____

_____

Do you take Aspirin Motrin or Aleve? Yes_____No____ Do you drink alcohol? Yes_____ No_____

Circle any of the following that have occurred in you or your family:

Allergies Asthma Diabetes Eczema Hayfever Psoriasis Thyroid problems Skin cancer

Occupation:_____ Lesiure activities_____

Doctor Initials:_____ Date reviewed:_____