



NORTH CAROLINA DERMATOLOGY ASSOCIATES

PLEASE FILL OUT AND BRING TO APPOINTMENT

Today's Date \_\_\_/\_\_\_/\_\_\_

Patient Name \_\_\_\_\_ Last First M.I.

Primary MD \_\_\_\_\_ Address/Phone/Fax \_\_\_\_\_

Referring MD \_\_\_\_\_ Address/Phone/Fax \_\_\_\_\_

Reason for Visit : 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ (Please limit to 3 problems during initial visit)

MEDICATIONS AND DRUG ALLERGIES

List current medications and dosage (prescription and non-prescription).

Three horizontal lines for listing medications and dosages.

Have you had any allergies or problems with local or dental anesthesia such as Novocaine?

No  Yes. Describe: \_\_\_\_\_

Are you allergic to latex?

No  Yes

Do you have any drug allergies?

No Known Drug Allergies  Yes. Please list below and indicate your reaction

Table with 2 columns: Drug / Allergen, Reaction. Rows for listing drug allergies and reactions.

PERSONAL MEDICAL HISTORY (Please be sure to check all that apply – past or present)

Do you require antibiotics prior to surgery or dental work?  No  Yes

- Acne, Anemia, Arthritis, Asthma, Atypical moles, Cancer, Crohn's Disease, Depression, Diabetes, type 1, Diabetes, type 2, Eczema, Epilepsy, Glaucoma, Hay fever, Heart attack, Heart failure, Hepatitis, Herpes simplex, Herpes zoster, High blood pressure, HIV, Lupus, Malignant melanoma, Mitral valve prolapse, Pacemaker, Psoriasis, Rheumatic fever, Scarring/keloids, Skin cancer, Basal Cell, Squamous Cell, Melanoma, Stroke, Thyroid Disease, Tuberculosis, Vitiligo

Other: \_\_\_\_\_

**REVIEW OF SYSTEMS (ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?)**

**GENERAL**

- weight gain / loss
- loss of appetite
- fever / chills
- weakness
- night sweats
- chronic infections

**OB/GYN (Females only)**

- currently pregnant
- possibly pregnant
- trying to get pregnant
- taking oral contraceptives
- irregular menstrual period

**DERMATOLOGY**

- rash
- lumps
- dry/sensitive skin
- hives
- suspicious moles
- suspicious lesions
- jaundice
- acne
- itching
- hair loss
- skin ulcers
- wounds difficulty healing

**SOCIAL HISTORY**

What is your occupation? \_\_\_\_\_

Do you drink alcohol?  Yes  No If YES \_\_\_\_\_ drinks per day. How often? \_\_\_\_\_

Do you smoke?  Yes  No If YES \_\_\_\_\_ packs per day.

Do you use sunscreen?  Yes  No  Sometimes

Do you have a history of extensive sun exposure or blistering sunburns?  Yes  No

Do you have a history of tanning bed use  Yes  No

**FAMILY HISTORY**

Disease/Condition/Disorder	Father	Mother	Brother	Sister	Child	Disease/Condition/Disorder	Father	Mother	Brother	Sister	Child
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer-melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer-basal or squamous cell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	None of the above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Disorders or Relatives: \_\_\_\_\_