



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).

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

Drug / Allergen	Reaction
	<input type="checkbox"/> Shock <input type="checkbox"/> Breathing problems <input type="checkbox"/> Rash <input type="checkbox"/> Nausea <input type="checkbox"/> Other _____
	<input type="checkbox"/> Shock <input type="checkbox"/> Breathing problems <input type="checkbox"/> Rash <input type="checkbox"/> Nausea <input type="checkbox"/> Other _____
	<input type="checkbox"/> Shock <input type="checkbox"/> Breathing problems <input type="checkbox"/> Rash <input type="checkbox"/> Nausea <input type="checkbox"/> Other _____
	<input type="checkbox"/> Shock <input type="checkbox"/> Breathing problems <input type="checkbox"/> Rash <input type="checkbox"/> Nausea <input type="checkbox"/> Other _____

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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Diabetes, type 2 | <input type="checkbox"/> Herpes zoster (shingles) | <input type="checkbox"/> Scarring/keloids |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV (AIDS) | <input type="checkbox"/> Basal Cell |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Lupus | <input type="checkbox"/> Squamous Cell |
| <input type="checkbox"/> Atypical moles | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Malignant melanoma | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Heart attack (yr____) | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes, type 1 | <input type="checkbox"/> Herpes simplex (cold sores) | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> 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? Yes No

Do you have a history of multiple blistering sunburns? Yes No

Do you have a current history of tanning bed use Yes No

Do you have past 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: _____