

AUBURN DERMATOLOGY

Name: _____ DOB: ____/____/____

Reason for Visit: _____

Medical History: Please check any boxes if you have **now or have ever** suffered from the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Aids risk/HIV | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Eczema/Dermatitis | <input type="checkbox"/> Cancer – specify _____ | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Headache/migraine | <input type="checkbox"/> Hepatitis A, B or C |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Lung or Breathing Disorders | <input type="checkbox"/> Lupus/LE | <input type="checkbox"/> Keloid Scar/Poor wound healing |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Neurological/Epilepsy | <input type="checkbox"/> Increased cholesterol |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Heart valve trouble |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Varicose Veins/spider veins | <input type="checkbox"/> Blistering Sunburn |

Have you ever had skin cancer? What type and where? _____

Please list any **operations** you have **ever** had: _____

Is there **anything else** not listed, that you currently have or have ever had treatment from a doctor for?
Please specify: _____

Are you **allergic** to any medications? Please specify: _____

Please list any **medications** you currently take including **prescribed, over the counter, herbal remedies** (include dose and frequency): _____

Please only check boxes that apply:

- Do you have a pacemaker? _____ Do you have a Defibrillator? _____
- Are you pregnant? Or think you may be pregnant? Due date: _____
- Do you need antibiotics before dental work?
- Do you take blood thinners i.e. Aspirin or warfarin, coumadin, plavix
- Do you bleed easily?
- Have you ever had problems with local anesthesia? If yes, what? _____
- Have you ever had problems with topical antibiotics? (Neosporin, triple antibiotic, polysporin)

Family History: Are any of the following illness/conditions in your immediate family; parents, siblings, children?

- | | | | |
|---|----------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Vitiligo | <input type="checkbox"/> Keloid Scar |
| <input type="checkbox"/> Skin cancer: type? _____ | | | |

Life Style:

- Smoking Yes No Cigarettes/day _____
- Alcohol Yes No How much? _____
- Illegal Drugs Yes No Type? _____

Have you ever had **Laser treatment, implants or cosmetic procedures**? I.e. Fillers, collagen, chemical peels, silicon, Botox, Laser: _____

It is essential that you complete this form accurately. Failure to do so may result in incorrect treatment and compromise your safety, for which the Auburn Dermatology will not be responsible.

Signature: _____ Date: _____