INTEGRATED
DERMATOLOGY

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Integrated Dermatology of North Raleigh
3809 Computer Drive; Suite 200
Raleigh, NC 27609

Patient Registration & Health History

Date: _____

Name: _____ **DOB:** _____ **Sex: M/F SSN:** ____-___-_____

Address: _____ **City:** _____ **State:** _____ **Zip** _____

Telephone Number Home _____ **Cell** _____ **Work** _____

How did you hear about us? _____

Primary Care Physician: Dr. _____ **Phone:** _____

Reason for Visit (One or Two Main Problems to Address Today): _____

_____

Duration of Problem: _____

Treatment: _____

Aggravating factors: _____

Current Medications (please include OTC, herbs, vitamins, supplements): _____

_____

_____

Allergies to Medication: ☐None ☐Other _____

Other Allergies: ☐**None** ☐**Latex** ☐**Bandages/Adhesive**

☐**Topical Antibiotic (Neosporin or other)** _____

Have you ever had any bad reaction to local anesthesia? ☐**No** ☐**Yes** ☐**Never had anesthesia**

PAST Medical History: _____

_____

PAST Surgeries (Type and Date):

_____

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FAMILY HISTORY: ☐ Eczema ☐ Psoriasis ☐Melanoma ☐Other_____

SOCIAL HISTORY:

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow/Widower

Occupation: _____

Smoking: ☐No ☐Former ☐Yes, packs/day _____

Alcohol: ☐No ☐Yes, how much/often _____

Flu Shot: No Yes

Pneumonia Vaccine: No Yes

COVID 19 Vaccine: No Yes

FOR WOMEN ONLY:

Are you currently pregnant, trying to become pregnant, or are you nursing? _____

Are you on a contraceptive, if so what form? _____

SKIN CONDITIONS:

Have you ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Where? _____When? _____

Treatment? _____

Has anyone if your family ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Who? _____

Do you have a history of any skin problems or diseases? ☐No ☐Yes

If Yes, ☐Psoriasis ☐Eczema ☐Keloid ☐Other _____

Are you experiencing hair loss and/or thinning? ☐Yes ☐No

SUN EXPOSURE:

When you are exposed to the sun do you:

☐ always burn
☐ usually burn, tan minimally
☐ sometimes mild burn, tan uniformly
☐ rarely burn, always tan well
☐ very rarely burn, tan very easily
☐ never burn, tan very easily

Did you have: ☐ sunburns every summer in childhood
☐ at least one blistering sunburn, how many _____
☐ ever use a tanning bed, how many times/how often _____

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☐ regular sunscreen use, SPF _____

REVIEW OF SYSTEMS: Please check if you are experiencing of the following today.

ENT: ☐Headaches ☐Vertigo ☐Vision Changes

Constitutional: ☐Weight gain ☐Weight loss ☐Fevers ☐Night sweats

Cardiovascular: ☐Palpitations ☐Artificial Heart Valve ☐Pacemaker ☐Chest Pain

☐Other_____

Endocrine: ☐Excessive Sweating ☐Irregular Menses ☐Abnormal Hair Growth ☐Polycystic Ovarian Disease

Gastrointestinal: ☐Diarrhea ☐Constipation ☐Nausea

☐Other_____

Genital/Urinary: ☐Pain w/ urination ☐Ulcers in genital area ☐Urinary Discharge

Integumentary: ☐Rash ☐Acne ☐Dry Skin ☐New Growth ☐ Hair loss

☐Other_____

Musculoskeletal: ☐Muscle weakness ☐Restless Leg Syndrome ☐Joint Pain

Neurological: ☐Stroke ☐Seizures/Epilepsy ☐Multiple Sclerosis

☐Other_____

Respiratory: ☐Shortness of breath ☐Cough ☐Wheezing

Others: ☐Kidney Problems ☐Cold Sores ☐Varicose Veins

☐Require Antibiotics Prior to Dentistry

☐**Denies All**

By signing, I am acknowledging that I have disclosed all my health information known to me at this time, and all my other personal information is accurate. I understand that it is my obligation and responsibility to notify Integrated Dermatology of North Raleigh of any changes to my medical history so I may receive proper treatment.

❖ SIGNATURE_____ Date _____

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