☐ Use sunscreen regularly
☐ Used tanning beds in the past
☐ Cold sores

Please list location and dates of any skin cancers you have had prior to starting care at our practice:

Family History (in a family member)

☐ Family history of melanoma
☐ Family history of basal cell carcinoma
☐ Family history of squamous cell carcinoma
☐ Family history of skin cancer- not sure which type
☐ Family history or dysplastic/abnormal mole
☐ Family history of psoriasis
☐ Family history of eczema/atopic dermatitis

Please list which family members have had which types of skin cancer:

Review of Systems

☐ Seasonal allergies
☐ Taking immunosuppression
☐ Depression
☐ ADD/ADHD
☐ High blood pressure
☐ Irregular heartbeat (atrial fibrillation)
☐ History of stroke
☐ Thyroid disorder
☐ Inflammatory bowel disease (Crohn's or ulcerative colitis)
☐ Hepatitis B
☐ HIV/AIDS
☐ Anemia
☐ Breast cancer
☐ Other cancer (other than skin cancer, breast cancer, or prostate cancer)
☐ Arthritis- inflammatory
☐ Multiple sclerosis
☐ Emphysema
☐ Kidney disease
☐ Autoimmune condition (lupus, Sjogren's, other)
☐ Organ transplant
☐ Anxiety
☐ Fevers/night sweats
☐ High cholesterol
☐ History of heart attack
☐ Diabetes
☐ Acid Reflux
☐ Liver disease
☐ Hepatitis C
☐ Tuberculosis (or positive test for tuberculosis)
☐ Bleeding problems
☐ Prostate cancer
☐ Arthritis- osteoarthritis
☐ Arthritis- not sure which type
☐ Seizures/Epilepsy
☐ COPD

Please list any other medical problems:

Social History

☐ Drink alcohol
☐ Smoke tobacco cigarettes/use tobacco
☐ Formerly smoked tobacco cigarettes/used tobacco
☐ Use marijuana
☐ Use other street drugs
☐ Single
☐ Married
☐ Divorced
☐ Widow/Widower

Where did you grow up? _____

Occupation: _____

By signing, I am acknowledging that I have disclosed all of 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 Fairfax of any changes in my medical information during the course of my medical treatment.

Signature: _____ **Date:** _____

INTEGRATED DERMATOLOGY of Fairfax

Date: _____

Name: _____ **Age:** _____ **Date of Birth:** _____

Referred By: _____

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, and supplements):

_____

_____

Allergies to Medications:

_____

Any surgical history? Please list out:

_____

Pharmacy Information:

Name: _____ **Address:** _____

Phone: _____ **Fax:** _____

Check off items that apply to you. Feel free to add notes for checked items.

Patient History

- ☐ Allergy/reaction to lidocaine or any local anesthesia
- ☐ Allergy to topical antibiotics (Neosporin or Polysporin)
- ☐ Fainting/lightheaded with medical procedures or blood draws
- ☐ Taking blood thinner (including aspirin)
- ☐ Artificial joint
- ☐ Currently pregnant
- ☐ Currently trying to become pregnant
- ☐ Received flu vaccine this year
- ☐ Currently having pain?
- ☐ Allergy/Intolerance to epinephrine
- ☐ Allergy to bandages/adhesives
- ☐ Pacemaker or defibrillator in the heart
- ☐ Artificial heart valve
- ☐ Require antibiotics prior to dental procedures
- ☐ Currently nursing
- ☐ Identify as transgender
- ☐ Received pneumonia vaccine

Dermatological History

- ☐ History of melanoma skin cancer
- ☐ History of basal cell carcinoma skin cancer
- ☐ History of squamous cell skin cancer
- ☐ History of skin cancer- not sure which type
- ☐ History of dysplastic/abnormal moles
- ☐ Blistering sunburns in the past
- ☐ Psoriasis
- ☐ Eczema/atopic dermatitis
- ☐ Vitiligo
- ☐ Keloids