Tarrant Dermatology CONSULTANTS

Dermatology Associates of Parker County

Today's date:	**Referred by doctor:**

PATIENT INFORMATION

Last name:	**First:**	**M.I:**	**Date of birth:**

Primary Language: ☐ English ☐ Arabic ☐ French ☐ German ☐ Mandarin ☐ Spanish ☐ Russian ☐ Other

Race: ☐ American Indian ☐ Asian ☐ African American or Black ☐ Native Hawaiian/Other Pacific ☐ White ☐ Unknown ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Height: _____ft. _____in. Weight: _____lbs

Month & year of last flu vaccine: If 65+ y.o., have you had a pneumonia vaccine? ☐ Yes ☐ No

TOP 2 REASONS FOR TODAY'S VISIT

Concern:	Location:	Duration:	Prior Treatments:
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PERSONAL CRITICAL INFORMATION

Adhesive tape allergy	☐ Yes	☐ No
Latex allergy	☐ Yes	☐ No
Local anesthetics allergy	☐ Yes	☐ No
Epinephrine sensitivity	☐ Yes	☐ No
Bacitracin allergy	☐ Yes	☐ No
Neosporin allergy	☐ Yes	☐ No
Anticoagulant treatment	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No
Artificial joint	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No
Pacemaker / defibrillator	☐ Yes	☐ No
Melanoma	☐ Yes	☐ No
Mitral valve prolapsed	☐ Yes	☐ No
Immunosuppressed therapy	☐ Yes	☐ No
Organ transplant	☐ Yes	☐ No
CLL chronic leukemia	☐ Yes	☐ No
PreMedicate	☐ Yes	☐ No
Memory Problems	☐ Yes	☐ No
Fainting / syncope	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
If yes, list type(s): _____		
HIV positive	☐ Yes	☐ No
MRSA	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Abnormal scars	☐ Yes	☐ No
Poor wound healing	☐ Yes	☐ No

PERSONAL MEDICAL HISTORY

Arthritis	☐ Yes	☐ No
Asthma / Hay Fever	☐ Yes	☐ No
Bladder problems	☐ Yes	☐ No
Bowel problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
If yes, list type(s): _____		
Diabetes	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
HSV / cold sore	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Other autoimmune disease	☐ Yes	☐ No
Pre-op/pre-dental antibiotics	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No
Stomach problems	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Thyroid disease	☐ Yes	☐ No
Other: _____		

SKIN TYPE

When exposed to sunlight, do you (choose one):

☐ Always burn, never tan (I)
☐ Usually burn, sometimes tan (II)
☐ Often burn, tan slowly (III)
☐ Sometimes burn, tan well (IV)
☐ Rarely burn, always tan (V)
☐ Never burn, tan deeply (VI)

SKIN CANCER HISTORY

Do you have a personal history of melanoma? ☐ Yes ☐ No

Do you have a personal history of other skin cancer(s)? ☐ Yes ☐ No If yes, list type(s):

Last name:	**First:**	**M.I.:**	**Today's date:**

CURRENT MEDICATIONS

Medication:	Medication:	Medication:	Medication:
Medication:	Medication:	Medication:	Medication:
Medication:	Medication:	Medication:	Medication:

PHARMACY INFORMATION

Pharmacy name:	Phone / address:

MEDICATION ALLERGIES

List all drug allergies (**or "none"**):

FOR FEMALES ONLY

Are you pregnant? ☐ Yes ☐ No	Are you breastfeeding? ☐ Yes ☐ No	Are you on birth control? ☐ Yes ☐ No
Are you post-menopausal? ☐ Yes ☐ No	Do you have regular menstrual cycles? ☐ Yes ☐ No	

SURGERIES

List all past surgeries (**or "none"**):

FAMILY MEDICAL HISTORY

Do you have a family history of melanoma? ☐ Yes ☐ No		
Do you have a family history of other skin cancer(s)? ☐ Yes ☐ No	If yes, list type(s):	

Asthma	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Heart disease	☐ Yes	☐ No
Eczema	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Lupus	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Autoimmune disease	☐ Yes	☐ No	High cholesterol	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No	Kidney problems	☐ Yes	☐ No
Hair loss	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Pulmonary embolism	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Other: _____		
Cancer	☐ Yes	☐ No			

If yes, list type(s): _____

SOCIAL HISTORY

Occupation:	Animals in your home? ☐ Yes ☐ No	Type(s): _____
Do you use tobacco? ☐ Yes ☐ No	Alcohol consumption? ☐ None ☐ Social ☐ Moderate ☐ Heavy	
Do you use sunscreen? ☐ No ☐ Daily ☐ Occasionally	Tanning bed use? ☐ None ☐ Current ☐ Previous	
Have you had blistering sunburns? ☐ Yes ☐ No	Do you have a history of blood transfusion or IV drug use? ☐ Yes ☐ No	

CURRENT SYMPTOMS

Chills	☐ Yes	☐ No	Nausea/Vomiting	☐ Yes	☐ No	Joint pain	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Abdominal pain	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Fever	☐ Yes	☐ No	Constipation	☐ Yes	☐ No	Itching	☐ Yes	☐ No
Unintentional			Diarrhea	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
weight change	☐ Yes	☐ No	Heartburn	☐ Yes	☐ No	Headache	☐ Yes	☐ No
Eye Irritation	☐ Yes	☐ No	Easy bruising	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Chronic cough	☐ Yes	☐ No	Blood clots	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Swollen lymph nodes	☐ Yes	☐ No			