CHARLESTON
DERMATOLOGY

Name:_____ Date of birth:_____

Who is your primary care provider? _____

What brings you in today? (please check one of the boxes below):
☐ *rash*
☐ *mole, growth or other lesion of concern.*
☐ *other (please explain):* _____

Where is it located? (please select all that apply)
☐ *scalp* ☐ *face* ☐ *chest* ☐ *back* ☐ *abdomen* ☐ *buttocks/groin*
☐ *right arm* ☐ *left arm* ☐ *right leg* ☐ *left leg*

How long has the above been present?
_____ *days* _____ *weeks* _____ *months* _____ *years*

Do any of these symptoms or descriptions apply?
☐ *itching* ☐ *burning* ☐ *bleeding* ☐ *darkening* ☐ *enlarging* ☐ *not healing*
☐ *flaking* ☐ *blistering* ☐ *other (please explain):* _____

Have you tried any prescription or over-the-counter medications to treat this problem?
☐ *none*
☐ *topical medicine (please specify)* _____
☐ *oral antibiotic (please specify)* _____
☐ *oral prednisone (please specify the dose and duration)* _____
☐ *other (please specify the dose and duration)* _____

Please check all that apply:
☐ *I would like to address my chief concern today but schedule a skin evaluation in the future.*
☐ *I would like a complete skin evaluation today.*
☐ *I would like to decline a complete skin evaluation today.*
☐ *I am interested in scheduling a cosmetic consultation.*

Females only

Are you pregnant or planning a pregnancy?	☐ yes	☐ no
Are you a nursing mother?	☐ yes	☐ no

<u>Skin Disease History:</u> ***(please check all that apply):***

☐ *None*
☐ *Acne*
☐ *Asthma*
☐ *Blistering sunburns*
☐ *Tanning salon use*
☐ *Eczema*
☐ *Hay fever/Allergies*
☐ *Precancerous moles*
☐ *Psoriasis*

☐ *Other:* _____

Do you have a history of fever blisters? ☐ *yes* ☐ *no*

Have you ever had a skin biopsy? ☐ *yes* ☐ *no*

Have you ever had a skin cancer or "pre-cancer" (please check all that apply)?

☐ *None*
☐ *Pre-cancers/Actinic Keratosis*
☐ *Basal cell carcinoma*
☐ *Squamous cell carcinoma*
☐ *Melanoma skin cancer*

Do you have a family history of melanoma skin cancer?

☐ *No* ☐ *Yes. Which relative?:* _____

Medical History

Please check all that apply:

☐ *None*
☐ *Anxiety*
☐ *Arthritis*
☐ *Asthma*
☐ *Atrial fibrillation*
☐ *Autoimmune disease:* _____
☐ *Bone Marrow Transplantation*
☐ *BPH (enlarged prostate)*
☐ *Breast cancer history*
☐ *Chronic Obstructive Pulmonary Disease (COPD)*
☐ *Coronary Artery Disease*
☐ *Pacemaker or defibrillator*
☐ *Depression*
☐ *Diabetes*
☐ *Kidney disease*
☐ *GERD*
☐ *Hearing Loss*
☐ *Hepatitis*
☐ *High blood pressure (hypertension)*
☐ *HIV/AIDs*
☐ *High cholesterol*
☐ *Hyperthyroidism*
☐ *Hypothyroidism*
☐ *Leukemia*
☐ *Lung cancer*
☐ *Lymphoma*
☐ *Prostate cancer*
☐ *Radiation treatment*
☐ *Seizures*
☐ *Stroke*
☐ *Other:*_____

Past Surgical History:

Please check all that apply:

☐ *None*
☐ *Appendix*
☐ *Breast* _____
☐ *Colon* _____
☐ *Gallbladder*
☐ *Heart: stent placement*
☐ *Heart: coronary artery bypass surgery*
☐ *Heart: biological valve replacement*
☐ *Heart: mechanical valve replacement*
☐ *Heart: heart transplant*
☐ *Joint replacement: left hip*
☐ *Joint replacement: right hip*
☐ *Joint replacement: left knee*
☐ *Joint replacement: right knee*
☐ *Kidney transplant*
☐ *Liver transplant*
☐ *Splenectomy*
☐ *Tonsillectomy*
☐ *Other:*_____

Medications:

What pharmacy do you use *(ie. CVS, Walgreens, etc)?_____*

What street is your pharmacy on ***OR*** *what is their phone number?_____*

List All Medications: (including over the counter medications)

☐ *I take no medications*

☐ *See attached medication list (if you've brought your medication list with you)*

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES (please list (or check) all that apply):

☐ *I have no known allergies*

☐ *Penicillin* ☐ *Lidocaine* ☐ *Sulfa*

☐ *Adhesive (medical tape)* ☐ *Latex* ☐ *Neosporin (or other topical antibiotic)*

☐ *Other _____*

Please select one of the following (optional):

Race: ☐ *White*
☐ *Black/African American*
☐ *Asian American*
☐ *Indian/Native Alaskan*
☐ *Native Hawaiian/Pacific Islander*
☐ *Other _____*

Ethnicity: ☐ *Hispanic/Latino*
☐ *Non-Hispanic/Latino*

Preferred Language: ☐ *English* ☐ *Spanish* ☐ *Other:_____*

Please check all that apply:

Have you had your flu shot this year? ☐ *Yes* ☐ *No*

Have you had your pneumonia shot? ☐ *Yes* ☐ *No*

Smoking History: ☐ *Never smoked*

☐ *Quit: former smoker*

☐ *Current Smoker:* *# packs/day: _____* *Total years: _____*

Alcoholic beverages: ☐ *None*

☐ *Less than 1 drink per day*

☐ *1-2 drinks per day*

☐ *More than 3 drinks per day*