GREATER WASHINGTON DERMATOLOGY / ADCS PATIENT INFORMATION SHEET

MEDICAL HISTORY

Name: _____

Past Medical History (Circle all that apply)

Anxiety	COPD	Hepatitis	Lung Cancer
Arthritis	Coronary Artery Disease	Hypertension	Lymphoma
Asthma	Depression	HIV/AIDS	Prostate Cancer
Atrial Fibrillation	Diabetes	Hypercholesterolemia	Radiation Treatment
BPH	End Stage Renal Disease	Hyperthyroidism	Seizures
Breast Cancer	GERD	Hypothyroidism	Stroke
Colon Cancer	Hearing Loss	Leukemia	Other: _____

Past Surgeries: _____

Skin History (Circle all that apply)

Acne	Blistering Sunburns	Hay Fever or Allergies	Psoriasis
Actinic Keratosis	Dry Skin	Melanoma	Squamous Cell Skin Cancer
Asthma	Eczema	Poison Ivy	Other: _____
Basal Cell Skin Cancer	Flaking or Itchy Scalp	Precancerous Moles	_____

Do you wear sunscreen? YES NO **Family history of Skin Cancer?** YES NO

If YES, which relative? _____

If YES, what type? (Please Circle): BASAL SQUAMOUS MELANOMA UNKNOWN

Are you currently taking any medications? YES (Please List) NO

_____

_____

_____

Are you allergic to any medications? YES (Please List) NO

Vaccinations (Month/Year Received): Pneumonia: _____/_____ Flu Shot: _____/_____

Alcohol Usage (Please Circle): NONE LESS THAN 1 PER DAY 1-2 PER DAY 3 OR MORE PER DAY

Smoking Status (Please Circle): EVERY DAY SOME DAY FORMER SMOKER NEVER SMOKER

Are you pregnant or planning a pregnancy? YES NO

Please circle any you currently have (ROS):

Problems with bleeding	Unintentional weight loss	Neck Stiffness	Allergy to lidocaine
Problems with healing	Thyroid Problems	Headaches	Allergy to topical antibiotics
Problems with scarring	Sore Throat	Seizures	Artificial heart valve
Rash	Blurry Vision	Cough	Artificial joints
Immunosuppression	Abdominal Pain	Shortness of breath	Blood thinners
Hay Fever	Bloody Stool	Wheezing	Defibrillator
Chest Pain	Bloody Urine	Anxiety	MRSA
Fever or Chills	Joint Aches	Depression	Pacemaker
Night Sweats	Muscle Weakness	Allergy to adhesive	Rapid pulse w/epinephrine