Chatham Dermatology

MEDICAL INFORMATION

Internal diseases, cancers, genetic issues, and medications can cause and present with *skin problems*. Thus, we need COMPLETE information about your skin, medical conditions, family history, social history, and medications.

Please give this form proper attention.

SKIN INFORMATION / HISTORY

Ethnic / racial heritage _____

Natural hair color_____ Eye color_____

Height _____ Weight _____

Is your face? □ Dry □ Oily □ Normal □ Combination □ Sensitive

Pigmentation problems? _____

Products that have irritated your skin? _____

□ Acne □ Rosacea □ Scalp Dermatitis or Dandruff

□ Dry Skin □ Eczema or Atopic Dermatitis □ Hives / Urticaria

□ Psoriasis □ Psoriatic Arthritis □ Cold sores/fever blisters

□ Other skin disorder(s) _____

SUN INFORMATION / HISTORY

□ Excessive sun □ Tanning bed usage □ Problems with sun

□ "Precancers" □ Atypical or dysplastic or abnormal moles

□ Skin CANCER(s) – type, location, year, treatment (write on back or separate sheet if needed)

_____

_____

Outdoor activities (gardening, fishing, sports, etc.)

_____

Sun protection used: □ UPF clothing □ long sleeves □ hats

□ sunglasses □ gators/buffs □ sunscreen □ seek shade

Which best describes your pattern of tanning?

□ Burn easily; get red and never really tan
□ Burn easily; light tan with some difficulty
□ May burn initially but able to tan
□ Rarely burn; tan easily
□ Never burn; tan deeply

ALERTS

□ Blood thinners? _____

□ Bleeding disorder/problems □ HIV □ Hepatitis

□ Healing problems □ Bad scars/keloids □ Staph/MRSA infections

□ Radiation treatment in past _____

□ **Organ transplant** _____

□ Artificial heart valves □ Artificial joint(s)_____

□ Pacemaker □ Defibrillator □ Other implanted device _____

□ Require antibiotics before dental work/surgery

□ Local anesthesia problems/reactions (lidocaine, epinephrine)

_____

□ Contact Dermatitis / Skin Sensitivities

□ Latex □ Adhesives/tape/bandages □ Antibiotic ointment

□ Nickel □ Fragrance □ Plants (poison ivy) □ Other _____

MEDICAL & FAMILY HISTORY

	Condition	Patient	Family (Who?)	None
SKIN	Skin Cancer	□	□ _____	□
	Melanoma	□	□ _____	□
	Eczema	□	□ _____	□
	Psoriasis	□	□ _____	□
EENT	Eye Disorder	□	□ _____	□
	Hearing disorder	□	□ _____	□
RESPIRATORY	Lung Disease	□	□ _____	□
	Asthma / COPD	□	□ _____	□
	Tuberculosis	□	□ _____	□
	Sinus Problems	□	□ _____	□
	Allergies	□	□ _____	□
CARDIOVASCULAR	Blood Clots	□	□ _____	□
	Stroke	□	□ _____	□
	Heart arrythmia	□	□ _____	□
	Heart valve issues	□	□ _____	□
	Heart attack	□	□ _____	□
	Hypertension	□	□ _____	□
IMMUNOLOGIC	Thyroid Disease	□	□ _____	□
	Diabetes	□	□ _____	□
	Arthritis	□	□ _____	□
	HIV/AIDS	□	□ _____	□
	Lupus	□	□ _____	□
	Multiple Sclerosis	□	□ _____	□
	Crohn's Disease	□	□ _____	□
	Ulcerative Colitis	□	□ _____	□
GU	Kidney Disease	□	□ _____	□
	Enlarged Prostate	□	□ _____	□
GI	Liver Disease	□	□ _____	□
	Reflux	□	□ _____	□
	Hepatitis	□	□ _____	□
CNS	Seizures	□	□ _____	□
	Mental Illness	□	□ _____	□
	Dementia	□	□ _____	□

OTHER DISORDERS

_____

SURGERIES

_____

CANCERS

_____

SOCIAL HISTORY Hours of sleep nightly _____

Smoking □ No □ Yes Amount_____

Alcohol □ No □ Yes Amount_____

Exercise □ No □ Yes Amount_____

Pets □ No □ Yes Type_____

Children □ No □ Yes _____

FEMALES

Sexually active □ Yes □ No

Birth Control _____

□ Tubal ligation

□ Hysterectomy

Signature

_____

Print Name _____

□ Patient □ Parent □ Legal Guardian

Date: _____