Dermatology Associates at Crystal Run

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PATIENT HISTORY UPDATE

Today's Date: _____

Name _____ _____ _____ Date of Birth: _____
Last *First* *Middle Initial*

Please describe the reason for today's visit: _____

_____

_____

Are you allergic to any medications? ◯ YES ◯ NO *If yes, please list, and describe reaction(s) to the medication(s):*

_____

_____

Have your medications CHANGED since your last visit (added, discontinued, dosage change)? ◯ YES ◯ NO *If yes, please list:*

_____

_____

Do you smoke? ◯ YES ◯ NO ☐ I QUIT smoking

Are you pregnant? ◯ YES ◯ NO Are you breast-feeding? ◯ YES ◯ NO

Do you have any NEW medical conditions / illnesses since your last visit? ◯ YES ◯ NO *If yes, please list:*

_____

_____

_____

Have you been treated for SKIN CANCER since your last visit? ◯ YES ◯ NO

If yes, what type? ☐ Basal Cell Carcinoma ☐ Squamous Cell ☐ Melanoma

Have you had any kind of surgery since your last visit? ◯ YES ◯ NO If yes, *please list:*

Date: _____ Surgery: _____

Date: _____ Surgery: _____

May we CALL you with lab results? ◯ YES ◯ NO Phone #: _____

May we EMAIL your lab results? ◯ YES ◯ NO Email: _____

May we call you at work / cell phone? ◯ YES ◯ NO Work phone#: _____ Cell#: _____

Is it okay to leave a message on your voice mail or answering machine? ◯ NO ◯ YES

Is it okay to speak with another person regarding your SKIN condition? ◯ NO ◯ YES

If yes, please list name(s) _____

_____