Dermatology Consultants of Marin, Inc.

Patient Information

Name ______________________________ Birth Date ____________ Date ____________

Pharmacy of choice : ________________ City ______________________

Have you ever had, or do you have the following conditions

	Yes	No	
Heart Problems	____	____	Type: ______________
Mitral Valve Prolapse	____	____	
High Blood Pressure	____	____	
Hepatitis/Liver Problems	____	____	
Diabetes	____	____	
Lung Problems	____	____	Type: ______________
Internal Cancer	____	____	Type: ______________
Immune Deficiency (HIV/lymphoma)	____	____	Type: ______________
Blood Transfusions	____	____	
Bleeding Problem	____	____	
Anxiety	____	____	
Depression	____	____	
Metal Implants (Plates/Wires)	____	____	
Artificial Valve/Pacemaker	____	____	

Do you routinely take:

	Yes	No	
Aspirin	____	____	
Ibuprofen	____	____	
Blood Thinners	____	____	**Type:** ________

History of skin cancer	____	____	Type? __________ Treatment? __________
History of keloid scarring	____	____	
History of radiation exposure	____	____	

Family history of melanoma Yes No What relation? ______________

Do you take antibiotics before dental work? Yes No Why? ______________

Which physician recommended these antibiotics? ______________________

Are you pregnant? __________ Nursing? __________

List Current Medication(s): ____

____

Are you allergic to any medications? Yes No

If yes, please list medication(s) and reaction(s): ______________________________

Social History: (**please circle all that apply**) Cigarette smoking: Never smoke, Quit: Former smoker, Smokes less than daily, Smokes Daily

Skin Disease History: (**Please circle all that apply**)

Acne	Hay Fever/Allergies	Blistering Sunburns	Dry Skin
Actinic Keratoses	Melanoma	Squamous Cell Carcinoma	
Asthma	Poison Ivy	Eczema	Flaking Or Itchy Scalp
Basal Cell Carcinoma	Precancerous Moles	Psoriasis	Other: ______________

Do You Wear Sunscreen? Yes No What SPF? ______