DERMATOLOGY CONSULTANTS OF MARIN, INC.

5000 Civic Center Drive
San Rafael, CA 94903
Phone 415-499-0100
Fax 415-499-0290

599 Sir Francis Drake Blvd.
Greenbrae, CA 94904
Phone 415-757-4515
Fax 415-524-8305

Name: Birth Date:

Preferred Pharmacy/Location:

	YES	NO	
PAST MEDICAL HISTORY			
Anxiety	☐	☐	
Asthma/Lung Problem	☐	☐	
Please mark if you have a: ☐ Artificial Heart Valve ☐ Pacemaker ☐ Defibrillator			
Bleeding Problems or Taking Blood Thinners	☐	☐	Name of blood thinner:
Blood Transfusions	☐	☐	
Depression	☐	☐	
Diabetes	☐	☐	
Heart Problems	☐	☐	
Hepatitis/Liver Problems	☐	☐	
High Blood Pressure	☐	☐	
History of Keloid Scarring	☐	☐	
History of Radiation Exposure	☐	☐	Location: Year:
Immune Deficiency (HIV/Lymphoma)	☐	☐	Type:
Internal Cancer	☐	☐	Location: Year:
Metal Implants/Joint Replacements	☐	☐	Location: Year:
Mitral Valve Prolapse	☐	☐	
Please mark if you are: ☐ Pregnant ☐ Breastfeeding ☐ Trying to conceive			
SKIN DISEASE HISTORY			
Acne	☐	☐	
Blistering Sunburns	☐	☐	
Dry Skin/Eczema	☐	☐	
Flaking or Itchy Scalp	☐	☐	
Hay Fever/Allergies	☐	☐	
Poison Oak/Ivy	☐	☐	
Psoriasis	☐	☐	
SKIN CANCER HISTORY			
Actinic Keratoses (Pre-Cancers)	☐	☐	
Atypical Moles/Precancerous Moles	☐	☐	Location: Year:
Basal Cell Carcinoma	☐	☐	Location: Year:
Squamous Cell Carcinoma	☐	☐	Location: Year:
Malignant Melanoma/Melanoma in Situ	☐	☐	Location: Year:
Family History of Melanoma	☐	☐	Relative:
DO YOU ROUTINELY TAKE THE FOLLOWING MEDICATIONS?			
Aspirin/Ibuprofen	☐	☐	
Do you take antibiotics prior to dental work?	☐	☐	Type: Prescribing Dr.:

Please list medication **ALLERGIES** with side effects, if any:

Please list any medications or supplements you take, with dosages:

Do we have your permission to download your medication list from your pharmacy? ☐ Yes ☐ No

Social History: ☐ Never smoked ☐ Former smoker ☐ Smokes daily (☐ Tobacco ☐ Cannabis)

Print Submit