Rock Creek Dermatology

Patient Name:			Age:
Preferred Pharmacy:		Pharmacy Phone Number:	
Can we leave a voicemail? Yes No		Preferred Phone Number for Test Results:	
Please indicate with whom else we can discuss results: Parent	Spouse/Partner	Daughter/Son	Sibling

Reason for Today's Visit

Concern	Location on Body	Duration	Prior Treatment

Health History

Please answer the following:

Latex allergy	YES NO	Asthma	YES NO
Neosporin Allergy	YES NO	Arthritis	YES NO
Epinephrine Sensitivity	YES NO	Diabetes	YES NO
Adhesive Allergy	YES NO	High Blood Pressure	YES NO
Use of Bloodthinners	YES NO	High Cholesterol	YES NO
Immunosuppressed	YES NO	Hypothyroid	YES NO
Artificial Joints	YES NO	Radiation Treatment	YES NO
Pacemaker	YES NO	Seizures	YES NO
Artificial Heart Valves	YES NO	Stroke	YES NO
Hepatitis	YES NO	Actinic Keratosis	YES NO
Currently Pregnant/Breastfeeding	YES NO	Eczema	YES NO
HIV Positive	YES NO	Atypical Moles	YES NO
If yes	CD4 count _____ Viral Load ____	Psoriasis	YES NO

When did you receive your last flu vaccine? ______________________

When did you receive the pneumonia vaccine? __________________

Do you have a history of cancer? If so, what type. ____

Please list past surgeries: ____

Please list any other medical conditions: ____

Skin Cancer History

Date	Type of Skin Cancer	Location on Body	Treatment

Do any relatives have a history of melanoma?	Mother Father Sibling Grandmother Grandfather Aunt Uncle
Do any relatives have a history of other skin cancers?	Mother Father Sibling Grandmother Grandfather Aunt Uncle

Please complete both sides

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Current Medications		
Medication	Dosage	Frequency

Medication Allergies

Do you have any drug allergies? Yes No

If yes, please list: ______________________________

Social History

Do you use tobacco products? Never Former Current

How often do you drink alcohol? Never Less than 1 drink/day 1-2 drinks/day 3+drinks/day

Do you have a history of tanning bed use? Current Previous None

Review of Systems

At today's visit, are you experiencing any of the following symptoms:

Problems with Bleeding	YES	NO	Abdominal Pain	YES	NO
Rash	YES	NO	Bloody Urine	YES	NO
Hay Fever	YES	NO	Joint Aches	YES	NO
Chest Pain	YES	NO	Muscle Weakness	YES	NO
Fever or Chills	YES	NO	Headaches	YES	NO
Night Sweats	YES	NO	Seizures	YES	NO
Unintentional Weight Loss	YES	NO	Cough	YES	NO
Sore Throat	YES	NO	Depression	YES	NO
Blurry Vision	YES	NO	Anxiety	YES	NO

Please complete both sides