


  
**THE DERMATOLOGY CENTER OF RALEIGH**
  
••• skincare solutions for life

8300 Health Park – Suite 207 – Raleigh – 27615  
 Phone (919) 573-9030 Fax (919) 573-9029

**Health Information as of \_\_\_\_\_ (enter today's date)**  
**(Please Print Legibly & Fill In or Correct All Fields)**

<b>Patient:</b>					
DOB	Age	Marital Status		Weight	lbs
Reason for visit				Height	ft in

**Skin History:**

1. Skin Disorders: Yes/No *(If yes, circle all that apply)*  
 Acne Alopecia Atopic Dermatitis Cold Sores/Fever Blisters Eczema Genital Herpes  
 Genital Warts Herpes Simplex Psoriasis Rosacea Shingles Vitiligo
  
2. Atypical Moles Yes/No
  
3. Skin Cancer: Yes/No *(If yes, circle all that apply)*  
 Basal Cell Carcinoma Squamous Cell Carcinoma Bowen's Disease  
 Melanoma Malignant Melanoma Melanoma in situ  
 Location \_\_\_\_\_
  
4. Family History of Skin Cancer: Yes/No *(If yes, circle all that apply)*  
 Basal Cell Carcinoma Squamous Cell Carcinoma Bowen's Disease  
 Melanoma Malignant Melanoma Melanoma in situ  
 Who \_\_\_\_\_

DO YOU NOW OR HAVE YOU EVER HAD  
 ( Please check one box for each question)

	Yes	No		Yes	No
Anxiety/Panic Attack	<input type="checkbox"/>	<input type="checkbox"/>	GERD	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency or Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<b>Heart Problems</b> (Please specify)		
<b>Cancer</b> (Please specify)			Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Brain Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Other:		
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Positive Bloodtest for HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	s/p CABG	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
<b>GI Disorders</b> (Please specify)			Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Gallstone/Gallbladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Unknown	<input type="checkbox"/>	<input type="checkbox"/>

THE DERMATOLOGY CENTER OF RALEIGH

skincare solutions for life

8300 Health Park – Suite 207 – Raleigh – 27615
Phone (919) 573-9030 Fax (919) 573-9029

5. Please list all surgeries, including procedures done for cosmetic reasons:
SURGICAL OPERATIONS (include why and when (yr.) for each surgery):

6. Please list all present medications, including birth control pills, hormones, vitamins, herbal medication, diuretics,
and weight loss drugs. Include over-the-counter medications.

7. Do you have an allergic reaction to any medication? Yes No Which?

8. Please list all allergies (including the reaction)

9. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other
alcohol?
Yes No If so, how much?

10. Do you smoke? Yes No If so, how much? For how long?

11. Are you pregnant? Yes No N/A
(if applicable) Number of pregnancies? Number of children?

12. Do you use recreational drugs? Yes No (If yes, circle all that apply)
Marijuana Cocaine (smoked) Cocaine (sniffed) Heroin LSD Metamphetamine
Ecstasy Morphine Vicodin Other(s):

13. Who is your primary care physician, if any?

14. Pharmacy Name, Location, & Phone
Number:

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: Date: