Barrington-Park
DERMATOLOGICAL ASSOCIATES, P.C.

Date_____________________________ **Doctor**_______________________________________

Patient Name_______________________________ **Date of Birth**___________________________

PAST MEDICAL HISTORY

Please circle if you currently have or in past have had any of the following medical conditions:

Anxiety	Colon Cancer	Hearing Loss	Lung Cancer
Arthritis	COPD	Hepatitis	Lymphoma
Asthma	Coronary Artery	Hypertension	Prostate Cancer
Arterial Fibrillation	Depression	Elevated Cholesterol	Radiation Treatment
Enlarged Prostate	Diabetes	Hyperthyroidism	Seizures
Bone Marrow Transplant	Kidney Disease	Hypothyroidism	Stroke
Breast Cancer	GERD	Leukemia	Inflammatory Bowel Disease

Other

PAST SURGICAL HISTORY

What operations have you had? ____

____

SKIN DISEASE HISTORY

Please circle if you have had any of the following skin or skin-related conditions:

Acne	Dry Skin	Poison Ivy
Actinic Keratosis	Eczema	Precancerous Moles
Asthma	Itchy/Flaking Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	

Do you wear sunscreen? ______yes ______no If yes, what SPF?________________

Do you or have you ever tanned in a tanning salon? ______yes ______no

-OVER-

FAMILY HISTORY

Has anyone in your family had melanoma? ______yes ______no

If yes, which relative?____

Please list your current medications: ____

____

Are you allergic to any medications? ______yes ______no If yes, please list: _______________

____

Have you ever smoked?______yes ______no Do you currently smoke? ______yes ______no

Do you drink alcohol? ______yes ______no

If yes, how much? ___less than 1 drink per day ___1 to 2 drinks per day ___3 or more drinks per day

REVIEW OF SYSTEMS

Please circle if you are currently experiencing any of the following:

Joint aches

Rash

GI upset with antibiotics

Problems with bleeding

Problems with healing

Problems with scarring (keloids)

Immunosuppression

Anxiety

Depression

Headaches

Hay fever

Thyroid problems

Unexplained weight loss

Pacemaker

Defibrillator

Artificial joints in past two years

Artificial heart valve

Premedication prior to procedures

Allergy to adhesive

Blood thinners

Allergy to lidocaine

Pregnancy or planning a pregnancy

Rapid heartbeat with epinephrine

Yeast infections with antibiotics

Latex allergy

-OVER-

MEDICATIONS

Please list your current medications with dosage & instructions:

______________________	_______________	____________________________________
______________________	_______________	____________________________________
______________________	_______________	____________________________________
______________________	_______________	____________________________________
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FOR OFFICE USE ONLY:

Return in ____Days _____Weeks ____Months ____PRN

Biopsy Office Visit Procedure