Today's Date:_____ Chart #_____

Memphis Dermatology Clinic Patient Information

Name._____**DOB**_____**M**__**F**__
Race_____**Ethnicity:** circle one Hispanic/non-Hispanic **Language**_____

Primary Care Provider_____

Who referred you to our office? Dr._____Other_____

Pharmacy:_____ **Phone(_)**_____

Your email address:_____

PLEASE CIRCLE ALL THAT APPLY TO YOU or circle NONE

Past Medical History

acid reflux
anxiety
arthritis
asthma
bone marrow transplant
enlarged prostate
COPD
depression
diabetes
hearing loss
high bloodpressure
cancer-_____
irregular heartbeat
organ transplant
radiation treatment
stroke
seizures
thyroid problems
hepatitis
high cholesterol
heart disease
Hepatitis A B C
HIV/Aids
none

other_____

_____
_____
_____

Skin Disease History

acne
actinic keratoses (pre-cancers)
basal cell carcinoma
blistering sunburns
dry skin
eczema
flaky or itchy scalp
hay fever/allergies
melanoma
poison ivy
pre-cancerous moles (abnormal moles)
psoriasis
squamous cell carcinoma
none
other_____

Are you in pain? Y/N

If So, rate on a scale of 0-10:

Have you been vaccinated for:

The flu (this year)? Y/N

Pneumonia (last 5 years)? YIN

Do you wear sunscreen? yes no
If yes, what SPF
Do you use tanning beds? yes no

Family history of skin cancer? yes no
If yes, who?_____
If yes, type?
basal cell carcinoma yes no
Squamous cell carcinoma yes no
malignant melanoma yes no

Are **YOU ALLERGIC** to any medications? YIN
If yes please list the medication and what kind of reaction you had to each:

_____

smoking: Please circle:
Never Smoker Former Smoker Current Smoker

Chart#_____

Medication List

Please list all medications that you take (including over-the-counter)
W not taking any please write N/A

	Medication Name	Dosage	How often do you take it
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Please complete below section only if you are a new patient

Review of Systems and Alerts

Please circle all that *currently* apply to you or circle "none"

Problems with Bleeding
Problems with Healing
Problems with Scarring Rash
Immunosuppression Hay
Fever/Chills
Chest Pain
Shortness of Breath
Headaches
Unintentional Weight Loss
Defibrillator
Abdominal Pain
Hepatitis A B C
Premedication to Prior Procedures

Bloody Stool
Bloody urine
Joint Aches
Muscle Weakness
Neck Stiffness
Cough
Wheezing
Anxiety
Night Sweats
Thyroid Problems
Blurry Vision
HIV/Aids
Breastfeeding

Seizures
Allergy to Adhesives
Allergy to Lidocaine
Allergy to Epinephrine
Allergy to Topical Antibiotics
Artificial Heart Valve
Artificial Joints (last 2yrs)
Pacemaker
Depression
Sore Throat
Allergy to Latex
Pregnancy (or Planning)
None