Today's Date:______________ Chart #__________

Memphis Dermatology Clinic Patient Information

Name__________________________________**DOB**______________**M**__**F**__
Primary Care Doctor____________________________

Who referred you to our office? Dr.____________________Other________________

Pharmacy:______________________________

Pharmacy location:____________________ **Pharmacy phone(___)**____________

Your email address:____

PLEASE CIRCLE ALL THAT APPLY TO YOU OR CIRCLE *NONE*

Past Medical History

NONE
acid reflux
anxiety
arthritis
asthma
bone marrow transplant
enlarged prostate
COPD
depression
diabetes
hearing loss
high blood pressure
cancer-_______________
atrial fibrillation
radiation treatment
stroke
seizures
hyper/hypothyroid
dialysis
high cholesterol
heart disease
Hepatitis B C
HIV/Aids

organ transplant –type_________year__________

other-______________________________________

____

Skin Disease History

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

squamous cell carcinoma

other-________________________________

Do you use tanning beds?
Currently or in the past? Y/N

Have you been vaccinated for:

The flu (this year) Y/N
Pneumonia (last 5 years) Y/N
Shingles Y/N

Do you wear sunscreen?	yes no
If so, what SPF?_____	
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? Y/N
If yes please list the medication and what kind of reaction you had to each:

____

Smoking: Please circle:
Never Smoker Former Smoker Current Smoker

Are you pregnant, planning pregnancy or breastfeeding? yes/no

Chart#________

Medication List

Please list all medications that you take (including over-the-counter)
IF 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

<u>Please circle all that *currently* apply to you or circle "none"</u>

Problems with Bleeding
Problems with Healing
Problems with Scarring
Defibrillator/Pacemaker
Artificial Heart Valve
Artificial Joints
Premedication Prior to Procedures
Allergy to adhesives
Allergy to lidocaine
Allergy to epinephrine
Allergy to topical antibiotics
Allergy to latex

Joint Aches
Muscle Weakness
Neck Stiffness
Cough
Wheezing
Anxiety
Night Sweats
Thyroid Problems
Blurry Vision
Rash
Abdominal pain
Bloody Stool
Bloody Urine

Seizures
Depression
Sore Throat
Immunosuppression
Fever/Chills
Chest Pain
Shortness of Breath
Headaches
Unintentional Weight Loss

NONE