Metropolitan Dermatology

TO HELP US GIVE YOU THE BEST POSSIBLE CARE, PLEASE COMPLETE ALL QUESTIONS.

Do you take any medicine, drugs, or over-the-counter preparations or remedies? ……..…….yes no
If yes, please list: _____

_____

Have **you** ever had or been treated for any of the following? (*Circle all that apply*)

- Excessive sun exposure in childhood
- Sunburns
- Melanoma
- Skin cancer
- Keloids or excessive scars
- Allergy to local anesthetics
- Excessive bleeding
- Difficulty with the healing
- Psoriasis
- Liver disease
- Lung disease
- Heart disease
- High blood pressure
- HIV
- Hepatitis B or C
- Kidney disease
- Venereal disease
- Cancer (other than skin)
- Neurological disorder
- Emotional or psychiatric problem
- Blood or lymph gland disorder
- Arthritis, joint problem or bone disease
- Diabetes
- Ulcer or intestinal disease
- Conditions requiring prophylactic antibiotics

Other conditions (please specify) _____

Have you previously had a skin problem or been under the care of a dermatologist? (If yes, please describe)

_____

Are you **ALLERGIC** to any medicines, drugs, over-the counter preparations or anything else……..yes no
If yes, please list_____

Prior hospitalization or surgery (Please specific surgery and dates)

_____

Have any members of your **family** had, specify who: (*Circle all that apply*)

- Asthma/Hay fever/Eczema
- Clotting disorder
- Autoimmune disorder
- Other conditions (please specify) _____
- Psoriasis
- Melanoma
- Cancer

Are you single, married, partnered, divorced, legally separated, widowed? _____

*Smoking status: (*Please circle one*)
Current every day smoker, current some day smoker, former smoker, never smoked.

Do you drink alcohol? ……..……yes no
*If yes, how often did you have six or more drinks on one occasion in the past year? *(Please circle one)*
Never, less than monthly, monthly, weekly, or daily/almost daily.

*If yes, how many drinks did you have on a typical day when you were drinking in the past year? *(Please circle one)*
1 or 2, 3 or 4, 5 or 6, 7 to 9, or 10+

*If yes, how often did you have a drink containing alcohol in the past year? *(Please circle one)*
Never, monthly or less, two to four times/month, two to three times/week, 4+ times/week
*Please note these questions are asked to comply with U.S. Government requirements.

~For Women Only (For pediatric patient mother/guardian):
~Are you pregnant, planning a pregnancy or nursing? _____
~Do you have regular menstrual periods? …….…… yes no

NOTE: THE DERMATOLOGICAL EXAMINATION WHICH YOU ARE ABOUT TO RECEIVE IS NOT A COMPLETE PHYSICAL EXAMINATION. IT IS SUGGESTED THAT YOU HAVE A COMPLETE PHYSICAL EXAMINATION PERIODICALLY BY YOUR FAMILY PHYSICIAN OR INTERNIST

Signature: _____ Date: _____