

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
- Excessive bleeding
- Difficulty with the healing
- Psoriasis
- Liver disease
- Lung or heart disease
- High blood pressure
- HIV
- Hepatitis B or C
- Kidney 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 _____

Do any medical conditions run in your family? (If yes, please describe)

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.

~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:** _____