TruDerm

Adult & Pediatric Dermatology & Cosmetic Center

Patient Name: _____ DOB: _____

Past Medical History: (please check yes or no)

Diabetes or high blood sugar?	□ yes	□ no	BPH	□ yes	□ no
Cancer_____	□ yes	□ no	Depression	□ yes	□ no
High blood pressure/hypertension?	□ yes	□ no	Breast Cancer	□ yes	□ no
Arthritis?	□ yes	□ no	Depression	□ yes	□ no
Asthma	□ yes	□ no	Colon Cancer	□ yes	□ no
Heart rhythm problems or pacemaker	□ yes	□ no	Stroke/ TIA	□ yes	□ no
Hepatitis C	□ yes	□ no	Leukemia	□ yes	□ no
Hepatitis B	□ yes	□ no	Migraine	□ yes	□ no
HIV/AIDS	□ yes	□ no	Lung problems	□ yes	□ no
Kidney Disease	□ yes	□ no	Tuberculosis	□ yes	□ no
Artificial Heart Valve	□yes	□ no	Glaucoma	□ yes	□ no
Blood thinners	□ yes	□ no	High cholesterol	□ yes	□ no
Thyroid disease	□ yes	□ no	Epilepsy	□ yes	□ no
Kidney disease	□ yes	□ no			

□ other _____

Any other medical problems. (if yes please explain below): _____

Do you need antibiotics before surgical/dental procedures? □ yes □ no

Past Surgical History: (please check all relevant)

Type	Year	Type	Year
AAA	_____	Colon Resection	_____
Angioplasty	_____	Cholecystectomy	_____
Back Surgery	_____	Colonoscopy	_____
Bladder surgery	_____	Joint/knee replacement	_____
Breast surgery/tumor	_____	Hysterectomy	_____
C-section	_____	Prostate surgery	_____
Coronary Artery Bypass Graph	_____	Appendectomy	_____
Cardiac Catheterization	_____	Kidney stone removal	_____
Mechanical Valve Replacement	_____	Pacemaker implant	_____
Heart Transplant	_____	Cosmetic Surgery	_____

Other_____

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Allergies to medications (please check)

☐ Ace Inhibitors	☐ Codeine	☐ Lidocaine	☐ Aspirin
☐ Epinephrine	☐ Morphine	☐ Tetracycline	☐ Barbiturates
☐ Iodine	☐ Penicillin	☐ Tegretol	☐ Retinoid
☐ Cephalosporin	☐ Kenalog	☐ Sulfa Drugs	

Other:_____

_____

Skin Disease History (please check all that apply)

☐ Acne	☐ Dry Skin	☐ Precancerous Moles
☐ Accutane Use	☐ Eczema	☐ Psoriasis
☐ Actinic Keratosis	☐ Itchy Scalp/Dandruff	☐ Squamous Cell Skin Cancer
☐ Asthma	☐ Allergies	☐ Sunburns (blistering)
☐ Basal Cell Cancer	☐ Melanoma	

Family History: (please check all that apply)

Melanoma	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter	☐ Other
Non-melanoma Skin cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter	☐ Other
Actinic keratosis	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter	☐ Other
Diabetes	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter	☐ Other
High Blood Pressure	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter	☐ Other
High Cholesterol	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter	☐ Other
Other: _____	☐ Mother	☐ Father	☐ Brother	☐ Sister	☐ Son	☐ Daughter	☐ Other

Social History: (please check all that apply)

Cigarette Smoking
- ☐ Never Smoked
- ☐ Quit: Former Smoker
- ☐ Smokes less than daily
- ☐ Daily

Alcohol:
- ☐ Never
- ☐ Socially (less than one drink/day)
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks/day

Sunscreen: ☐ yes ☐ no SPF_____

Do you tan in a tanning salon? ☐ yes ☐ no

Are you pregnant? ☐ yes ☐ no if yes due date: _____

Are you breastfeeding ☐ yes ☐ no

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Medications: Please enter all current medications including OTC, vitamins and herbal supplements

Medication	Dose	Frequency

Medicare Patients Attn:

1. Is this your first visit to our practice? □ yes □ no
2. Do you smoke? □ yes □ no
3. Have you ever received pneumonia vaccination? □ yes □ no
4. Did you receive the flu vaccine this flu season? □ yes □ no
5. Do you have a history of melanoma? □ yes □ no
6. Do you have an Advanced Directive? □ yes □ no
7. Do you have Psoriasis? □ yes □ no
8. Did you give us an updated medication list? □ yes □ no