WEST BLOOMFIELD DERMATOLOGY

NAME: ______________________ BIRTH DATE: ____________ AGE: ______

HOME ADDRESS: ______________________ HOME PHONE: ______________________

CITY: ______________________ CELL PHONE: ______________________

STATE / ZIP: ______________________ WORK PHONE: ______________________

OCCUPATION: ______________________

WHO IS YOUR PRIMARY CARE PHYSICIAN: ______________________

WHO REFFERED YOU TO THIS OFFICE: ______________________

Pharmacy Name: ______________________ **Pharmacy Number:** ______________________

Current Medications: ______________________

____

____

Allergies to Medications: (Circle) Penicillin Sulfa Erythromycin

Any Others: ______________________

Other Allergies: (Circle) Latex Adhesives

Foods: ______________________ Cosmetic Products: ______________________

Any Others: ______________________

Reason for your visit today: ______________________

____

☐ Skin Check ☐ Change in Mole ☐ Rash ☐ Warts ☐ Acne

☐ Other, please explain: ______________________

☐ Cosmetic Procedure: (Check) ☐ Botox / Dysport ☐ Spider Veins ☐ Peels ☐ Fillers ☐ Fraxel Laser

Personal History:

Have you ever had skin cancer? Yes / No If yes what type: ______________________

Family history of skin cancer? Yes / No (Circle): Basal cell Squamous cell Melanoma

Any other type of cancer? Yes / No If yes what type: ______________________

Psoriasis	Yes / No	Inflammatory Bowel Disease	Yes / No
Eczema or Atopic Dermatitis	Yes / No	Kidney Disease	Yes / No
Hay fever, Asthma or Hives	Yes / No	HIV / AIDS	Yes / No
High Blood Pressure	Yes / No	Bleeding Disorder	Yes / No
Heart Disease	Yes / No	Stomach Ulcers	Yes / No
Stroke / TIA	Yes / No	Tuberculosis	Yes / No
Diabetes	Yes / No	Lupus, Raynaud's, Scleroderma or	Yes / No
Liver Disease / Hepatitis / Jaundice	Yes / No	other Rheumatologic Disease	Yes / No

☐ Any Others Diseases:

Do you smoke? __________ How many glasses of Alcohol or Beer a week? __________

Have you ever been advised to take antibiotics before a procedure (such as dental work)? Yes / No

Do you take aspirin or blood thinners? Yes / No

Have you ever had Blood or Plasma transfusion? Yes / No

List any surgery you have had: ______________________

Patient's Signature: ______________________ **Date:** ______________________

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