wake forest dermatology

MEDICAL/DERMATOLOGY HISTORY CHECKLIST

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Reason for visit: _____

Have you had any previous treatment for this issue? If so, please list: _____

_____

List the medications you have taken for the above/effectiveness: _____

_____

Dermatological History: For any of the following symptoms or diseases, please mark (C) for current problems. For past problems, indicate your age when you experienced the symptom or disease.

___ ABNORMAL MOLES ___ ACNE ___ ACTINIC KERATOSIS ("PRE-CANCER") ___ ECZEMA
___ EXCESSIVE SCARRING ___ FREQUENT RASHES ___ FREQUENT SUN EXPOSURE ___ PSORIASIS
___ NON-HEALING/BLEEDING GROWTHS

History of Skin Cancer: Please check any of the following that apply. If any, please describe the type of treatment received.

___ BASAL CELL: _____
___ SQUAMOUS CELL: _____
___ MELANOMA: _____

Family History of Skin Problems & Skin Cancer: Please list condition/family member: _____

_____

Health Questionnaire

Medical History: For any of the following symptoms or diseases, please mark (C) for current problems. For past problems,indicate your age when you experienced the symptom or disease.

___ ALLERGIES (NON-DRUG) ___ ANEMIA ___ ARTHRITIS ___ ASTHMA ___ CANCER
___ CATARACTS ___ DIABETES ___ GLAUCOMA ___ HEART DISEASE ___ HEPATITIS
___ HIV/AIDS ___ HYPERTENSION ___ JAUNDICE ___ PEPTIC ULCERS ___ PHLEBITIS
___ SEIZURES ___ STROKE ___ THYROID DISEASE

Any other conditions not listed above: _____

Tobacco Use: _____ Alcohol Use: _____

Current Medications: Please list all current medications you are taking (including over-the-counter medications & herbal supplements):

_____

List any allergies to medications & your reaction: _____

_____

Hospitalization & Surgical History: Please list any hospitalizations or surgical procedures you received and the year in which it occurred:

_____

_____

Personal Skin Care Regimen:

When you are exposed to sunlight, do you (check only one): ❑ BURN Only ❑ BURN then TAN ❑ TAN Only

Do you wear (check all that apply): ❑ SUNSCREEN ❑ PROTECTIVE CLOTHING ❑ WIDE-BRIMMED HAT

Please list preferred brands and SPF amount: _____

Do you have a skin care regimen? ❑ YES ❑ NO

Please list and describe any preferred products. Also list prior products not preferred and why: _____

_____

Have you had any cosmetic procedures in the past? ❑ YES ❑ NO

Please list procedures and what you thought about the results: _____

Hobbies & Interests: Please list anything we should know about you & what you enjoy doing: _____

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