DOUGLASTON DERMATOLOGY

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Patient Name:_____ **Sex**: Male Female

Home Phone:_____ **Cell Phone**:_____ **Pharmacy Phone**: _____

Allergies to Medications: None 1. _____ Reaction _____
2. _____ Reaction _____

Current Medications: None 1. _____ 3. _____
2. _____ 4. _____

	Yes	No		Yes	No		Yes	No
Aspirin/Motrin/Advil	☐	☐	Birth Control Pills	☐	☐	Are you Pregnant	☐	☐
Coumadin	☐	☐	Are you breast feeding	☐	☐	Plan on becoming pregnant	☐	☐

Reviews of System (Current or past problems with)

	Yes	No		Yes	No		Yes	No
Blood/bleeding disorders	☐	☐	Arthritis	☐	☐	Cancer (non-skin)	☐	☐
Heart Disease	☐	☐	Diabetes (Sugar)	☐	☐	Immunologic Disease	☐	☐
Kidney Disease	☐	☐	High Blood Pressure	☐	☐	Latex/Rubber/Nickel/Food	☐	☐
Liver Disease or Hepatitis	☐	☐	Infectious Disease (TB, HIV)	☐	☐	Skin Disease	☐	☐
Lung Disease	☐	☐	Received Blood Transfusions	☐	☐	Skin Cancer	☐	☐
Thyroid Disease	☐	☐	Psychological Disorders	☐	☐	Melanoma	☐	☐

Do you	Yes	No		Yes	No
Have a pacemaker or defibrillator	☐	☐	Have an artificial joint or heart valve	☐	☐
Take antibiotics prior to surgical procedures	☐	☐	Form Keloids?	☐	☐

List Surgeries:
1._____ 3. _____ 5. _____
2._____ 4. _____ 6. _____

Family History (Check the following medical conditions which have occurred in your family)

Disease	Mother	Father	Blood Relative	Disease	Mother	Father	Blood Relative
Acne	☐	☐	☐	Hay Fever	☐	☐	☐
Arthritis	☐	☐	☐	Hives	☐	☐	☐
Asthma	☐	☐	☐	Lupus	☐	☐	☐
Cancer	☐	☐	☐	Melanoma	☐	☐	☐
Diabetes	☐	☐	☐	Psoriasis	☐	☐	☐
Eczema	☐	☐	☐	Skin Cancer	☐	☐	☐

Social History

	Yes	No	
Do you live alone?	☐	☐	
Do you drink alcohol?	☐	☐	Frequency _____
Do you use recreational drugs?	☐	☐	Frequency _____

Occupation: _____ **Hobbies/leisure activity**: _____

Patient signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____