ASHEBORO DERMATOLOGY AND SKIN SURGERY CENTER

Name : _____ Age : ____ Sex : M or F Date : _____

1.) Do you currently have or have you ever had any of these diagnoses / problems ?

Y N Asthma	Y N Cancer	Y N Bleeding Problems
Y N Blood Clots	Y N Diabetes	Y N Blood Transfusion
Y N Heart Attack	Y N Glaucoma	Y N Emotional Problems
Y N Heart Disease	Y N HIV	Y N High Blood Pressure
Y N Rheumatic Fever	Y N Kidney Disease	Y N Lung Disease
Y N Stroke	Y N Hepatitis/Liver Disease	Y N Bad Scarring Problem
Y N Seizures / Epilepsy	Y N Melanoma in Family	Y N Skin Cancer (which ?)
Y N Prosthetic Joint or Valve (which?) _____	Y N Wound Healing Problems	(Melanoma, Basal Cell or Squamous Cell Carcinoma)

2.) Circle any symptoms and conditions from the list that you might have :

Y N Lumps	Y N Easy Bruising	Y N Swollen/Stiff Joints
Y N Hoarseness	Y N Broken Bones	Y N Runny Nose
Y N Cough	Y N Deafness	Y N Shortness of Breath
Y N Swelling	Y N Nasal Bleeding	Y N Rapid Heart Beat
Y N Jaundice	Y N Weakness	Y N Ear Discharge
Y N Sore Throat	Y N Coughing up Blood	Y N Blood in Urine
Y N Hemorrhoids	Y N Breast Discharge/Pain	Y N Nausea / Vomiting

3.) Yes No If you are female, are you presently pregnant, planning a pregnancy or breastfeeding ? Circle any of the three that apply ?

4.) Yes No Please list all operations/surgeries you have had with *approximate* date :

_____

_____

_____

_____

5.) Yes No Do you smoke or chew tobacco ? About how much : _____

6.) Yes No Do you drink alcohol ? About how much : _____

7.) Yes No Are you allergic to any medicines ? Which ? _____

_____

8.) Yes No Please list the medicines you are taking including over the counter ones :

_____

_____

_____

_____

9.) How did you find out about our practice ? _____

_____

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