


ACCOUNT#	DERMATOLOGY INSTITUTE	 <small>DERMATOLOGY INSTITUTE COSMETIC & MEDICAL DERMATOLOGY</small>
DATE:	256 Landis Avenue, Third floor Chula Vista, CA 91910	

PAST SURGICAL HISTORY (please circle all that apply)

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Appendix removed • Bladder removed • Mastectomy (right, left, bilateral) • Lumpectomy (right, left, bilateral) • Breast biopsy (right, left, bilateral) • Breast reduction • Breast implants • Colectomy: colon cancer • Resection • Colectomy: diverticulitis • Colectomy: IBD • Gallbladder removed • Coronary artery bypass • PTCA • Mechanical valve | <ul style="list-style-type: none"> • Replacement • Biological valve • Heart transplant • Joint replacement, knee(right, left, bilateral) • Joint replacement, hip (right, left, bilateral) • Joint replacement within last 2 years • Kidney biopsy • Kidney removed (right, left) • Kidney stone removal • Kidney transplant • Ovaries removed: endometriosis • Ovaries removed: cyst • Ovaries removed: ovarian • Skin biopsy | <ul style="list-style-type: none"> • cancer • Prostate removed: prostate cancer • Prostate biopsy • TURP • Skin biopsy • Basal cell cancer surgery • Squamous cell carcinoma • Surgery • Melanoma surgery • Spleen removed • Testicles removed (right, left, bilateral) • Hysterectomy: fibroids • Hysterectomy: uterine • Cancer |
|--|--|---|

Other: _____

SKIN DISEASE HISTORY (Please circle all that apply)


- | | | |
|--|---|---|
| <ul style="list-style-type: none"> • Acne • Actinic keratosis • Asthma • Basal cell skin cancer • Blistering sunburns • Dry skin | <ul style="list-style-type: none"> • Eczema • Flaking or itchy scalp • Hay fever/Allergies • Melanoma • Poison ivy | <ul style="list-style-type: none"> • Precancerous moles • Psoriasis • Squamous cell skin • Cancer • none |
|--|---|---|

Other: _____

SOCIAL HISTORY: (Please fill in the bubble all that apply)

- Cigarette Smoking: Never smoked Quit: Former smoker Smoked less than ___ daily Smoked daily
- Sexual history: Not sexually active Sexually active with one partner Sexually active with more than one partner Same sex partner
- Illicit Drug use: Drug use IV drug use
- Alcohol use: Alcohol: none Alcohol: less than 1 drink a day Alcohol: 1-2 drinks a day Alcohol: 3 or more drinks a day

Other: _____

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PATIENT MEDICAL HISTORY

Last Name: _____ First Name: _____ Date: ___/___/___

Race: _____ Ethnic group: _____
(White, Asian, African American or black, native Hawaiian or Pacific Islander, American Indian or Alaska native, other race) (Hispanic or Latino, not Hispanic or Latino, unknown)

• Reason(s) for visit (list up to 3; include location, duration, symptoms, treatment):

1. _____
2. _____
3. _____

• Do you have any allergies to medications, latex or skin creams? YES NO

• If yes, please list

• List all medications, cream and supplements you are currently taking:

• List all your current medical conditions:

IMMEDIATE FAMILY HISTORY OF (select all that apply):

Breast cancer Uterine cancer Ovarian cancer Other _____

Do you wear sunscreen? YES NO

If yes, what SPF _____ 15, 30, 45, 50, 75

Do you tan in a tanning salon? YES NO

Do you have family history of melanoma? YES NO If yes, which relative(s)? _____

Any other family history: _____

PAST MEDIAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

- | | | |
|-----------------------|---------------------------|-----------------------|
| • Anxiety | • Diabetes | • COPD |
| • Arthritis | • End stage renal disease | • Hypothyroidism |
| • Artificial joints | • GERD | • Leukemia |
| • Asthma | • Hearing loss | • Lung cancer |
| • Atrial fibrillation | • Hepatitis | • Lymphoma |
| • BPH | • Hypertension | • pacemaker |
| • Bone marrow | • HIV/AIDS | • Prostate cancer |
| • Transplantation | • Hypercholesterolemia | • Radiation treatment |
| • Breast cancer | • Hyperthyroidism | • Seizures |
| • Depression | • Colon cancer | • Stroke |
| | | • Valve replacement |

Other: