

**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<br>Valve (which?) _____ | Y N Wound Healing<br>Problems | (Melanoma, Basal Cell or<br>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 ? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_