



JACKSONVILLE  
DERMATOLOGY  
ASSOCIATES, PL

## Information for Your Physician

Today's Date: \_\_\_\_\_

### Name:

\_\_\_\_\_

First

MI

Last

Describe in the space below your main dermatologic symptoms/problems, how long you have had them, and past treatment(s):

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**Past Medical History:** (*Check illnesses or conditions you have/had.*) Diabetes  Heart disease   
Vein trouble  High blood pressure  Artificial heart valve  Glaucoma  Abnormal bleeding   
Hepatitis  Arthritis  Liver problems  Stroke  Immunosuppression  Kidney problems   
Tuberculosis  Cancer  Asthma  Allergies   
Other infections/conditions

Do you have a pacemaker? Yes  No

Defibrillator? Yes  No

Other implanted electrical stimulatory device? Yes  No , please specify \_\_\_\_\_

### Skin Cancer History:

Basal cell carcinoma Yes  No  Squamous cell carcinoma Yes  No

Melanoma Yes  No  Dysplastic mole(s) Yes  No

### Drug Allergies:

Are you allergic to the following? (*Please check.*)

Latex  Tape  Polysporin  Lidocaine

### Current Medications (prescription, supplements, vitamins, aspirin, oral contraceptives):

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### Pharmacy

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Last menstrual period \_\_\_\_\_

**Family History:**

Basal cell carcinoma Yes  No  If yes, please specify which relative \_\_\_\_\_  
Squamous cell carcinoma Yes  No  If yes, please specify which relative \_\_\_\_\_  
Melanoma Yes  No  If yes, please specify which relative \_\_\_\_\_  
Dysplastic or atypical moles Yes  No  If yes, please specify which relative \_\_\_\_\_  
Psoriasis Yes  No  If yes, please specify which relative \_\_\_\_\_  
Eczema Yes  No  If yes, please specify which relative \_\_\_\_\_  
Autoimmune disease (lupus, vitiligo, thyroid, diabetes) Yes  No  If yes, circle condition.  
Other cancer or malignancy Yes  No  If yes, please specify type \_\_\_\_\_  
Other \_\_\_\_\_

**Social History:**

Do you wear sunscreen? Always  Occasionally  Never   
If yes, what SPF? 15 or less  15-30  30+   
Do you sunbathe? Frequently  Occasionally  Never   
Do you use tanning beds or salons? Frequently  Occasionally  Never   
Do you spend significant time performing outdoor activities? Frequently  Occasionally  Never   
Do you use tobacco? Yes  No  In the past? Yes  No   
Do you consume alcoholic beverages? Yes  No  Number per week \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_