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):

_____

_____

_____

_____

_____

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):

_____

_____

_____

_____

_____

Pharmacy (Name &Location)_____
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** _____