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NCCPA Board Certified
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Paducah DERMATOLOGY

Today's date:_____

PATIENT INFORMATION

Last Name:_____ First:_____ Middle:_____ Birth date: _____

Primary Language: ☐ English ☐ Spanish ☐ Other_____
Race: ☐ African American or Black ☐ American Indian ☐ Asian ☐ Native Hawaiian/Other Pacific ☐ White ☐ Other_____
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ _____

Primary Pharmacy:_____ Address:_____

Physician who requested that you see a dermatologist, if any:

Primary Care Doctor: _____

Specialist Physicians (cardiologist, gynecologist, etc.):_____

PAST MEDICAL HISTORY

Arrhythmia	☐ Yes	☐ No	Heart attack	☐ Yes	☐ No
Pacemaker / defibrillator	☐ Yes	☐ No	Heart failure	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No	Coronary Artery Bypass	☐ Yes	☐ No
Artificial joint	☐ Yes	☐ No	TIA	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Mitral valve prolapse	☐ Yes	☐ No	DVT/Thrombosis	☐ Yes	☐ No
Latex allergy	☐ Yes	☐ No	Pulmonary Embolism	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Hypertension	☐ Yes	☐ No
HIV positive	☐ Yes	☐ No	Insulin Dependent Diabetes	☐ Yes	☐ No
HSV / cold sore	☐ Yes	☐ No	Non-Insulin Dep. Diabetes	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Organ transplant	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No
Currently Pregnant	☐ Yes	☐ No	Hypothyroid disease	☐ Yes	☐ No
Serious infection requiring hospitalization or IV antibiotics (ex. MRSA, VRE, C. Diff)	☐ Yes	☐ No	Hyperthyroid disease	☐ Yes	☐ No
	☐ Yes	☐ No	Collagen Vasc. disease	☐ Yes	☐ No
	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
	☐ Yes	☐ No	Depression	☐ Yes	☐ No
	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
	☐ Yes	☐ No	Other:	☐ Yes	☐ No

FAMILY HISTORY

Do you have a family history of melanoma? □ Yes □ No Family member:
Do you have a family history of other skin cancer(s)? □ Yes □ No Family member:

SOCIAL HISTORY

Occupation:
Do you use tobacco? □ No □ Yes Packs per day:
Alcohol consumption? □ No □ Yes Drinks per week:
Do you use sunscreen? □ None □ Daily □ Occasionally
Tanning bed use? □ No use □ Current □ Previous # of visits:

CURRENT MEDICATIONS

Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:

MEDICATION ALLERGIES

Do you any medication allergies: ☐ Yes ☐ No
List allergies and type of reaction:

PAST SURGERIES

Please list any major surgeries you have had:

CURRENT SYMPTOMS

Fever	☐ Yes	☐ No	Blood clots	☐ Yes	☐ No
Unintentional weight loss	☐ Yes	☐ No	Swollen lymph nodes	☐ Yes	☐ No
Chronic cough	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Shortness of breath	☐ **Yes**	☐ No		☐ Yes	☐ No