

# The Dermatology and Skin Care Center of Birmingham, P.C.

## Patient History

Patient Name: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Patient Address: \_\_\_\_\_

\_\_\_\_\_

City/State

Patient Phone: (H) \_\_\_\_\_

(W) \_\_\_\_\_ Who referred you to our clinic? \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Email: \_\_\_\_\_

Reason for your visit: \_\_\_\_\_

### Medical History

Current Medical Problems

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

Medication Allergies: \_\_\_\_\_

\_\_\_\_\_

Surgeries:

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

### Current Medications

(including those for skin conditions)

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

Pregnant? YES NO Nursing? YES NO

### Family History

Has any blood relative ever had: If so, who?

Melanoma Yes No \_\_\_\_\_

Cystic Acne Yes No \_\_\_\_\_

Other Skin Cancer Yes No \_\_\_\_\_

Psoriasis Yes No \_\_\_\_\_

### Social History

Occupation \_\_\_\_\_ Married \_\_\_ Single \_\_\_ Widowed \_\_\_

Do you now or have you ever: (Please circle Yes or No and specify)

Use Illicit Drugs Yes No \_\_\_\_\_

Use Tobacco Products Yes No \_\_\_\_\_

Drink Alcohol Yes No \_\_\_\_\_

Please inform your health care provider of any cultural or spiritual issues that may affect your care.

# Review of Systems

Do you have or have you ever had: (Please circle Yes or No and give details) Not Circling a response is considered a "No" Answer.

Excess Bleeding	Yes	No	_____	Thyroid Disorders	Yes	No	_____
Artificial Heart Valve	Yes	No	_____	Diabetes	Yes	No	_____
Artificial Joint	Yes	No	_____	Frequent Nausea	Yes	No	_____
Blood Clots	Yes	No	_____	Constipation	Yes	No	_____
Chest Pain	Yes	No	_____	Weight Loss	Yes	No	_____
HIV	Yes	No	_____	Anxiety/Depression	Yes	No	_____
Hepatitis	Yes	No	_____	Mouth Sores	Yes	No	_____
Skin Rashes	Yes	No	_____	Frequent Urination	Yes	No	_____
Cancer	Yes	No	_____	Organ Transplant	Yes	No	_____
Chronic Cough	Yes	No	_____	Allergies	Yes	No	_____
Shortness of Breath	Yes	No	_____	Moles	Yes	No	_____
Pigment Lesions	Yes	No	_____				

Reviewed: \_\_\_\_\_/M.D. \_\_\_\_\_

Interval Change	Date/Initials
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please Note: New patient history forms must be completed each year