BEND DERMATOLOGY
CLINIC

Name:_____ **Birthdate**:_____

Personal Health History: (check all that apply):

○ Allergies / Hay Fever/ Asthma ○ Anemia ○ Arthritis ○ Artificial Heart Valve ○ Artificial Joint ○ Bleeding, excessive ○ Cancer ○ Cataracts ○ Colon/ Intestinal Disorder ○ Depression ○ Diabetes ○ Eczema ○ Epilepsy	○ Glaucoma ○ Headaches ○ Heart Problems ○ Hepatitis ○ Herpes Simplex (cold sores) ○ High Blood Pressure ○ HIV/ AIDS ○ Hives ○ Kidney Disease/ Problems ○ Liver Disease ○ Lupus/ Autoimmune Disorder ○ MRSA (staph) History ○ Neurological Problems	○ Pacemaker/Defibrillator ○ Psoriasis ○ Respiratory Problems ○ Skin Cancer: ○ *Basal Cell Carcinoma* ○ *Squamous Cell Carcinoma* ○ *Melanoma* ○ Scarring/ Keloids ○ Stroke ○ Thyroid Disorder ○ Tuberculosis ○ Ulcers ○ X-ray Therapy ○ Other:

Surgical History (past 2 years): _____

_____

_____

Family History: Is there a history in your family of the following diseases (check all that apply):

○ Acne ○ Allergies/ Hay fever/Asthma ○ Eczema ○ Heart disease ○ Lung disease ○ Psoriasis	○ Skin Cancer: ○ *Basal Cell Carcinoma* ○ *Squamous Cell Carcinoma* ○ *Melanoma* ○ Tuberculosis ○ Other cancer:

SUN EXPOSURE HISTORY:

Did/ Do you have an indoor occupation?	Yes	No
Did /Do you have an outdoor occupation?	Yes	No
Do you enjoy outdoor activities/ hobbies?	Yes	No
Were you raised in a sunny climate?	Yes	No
Have you had multiple blistering sunburns?	Yes	No
Have you used tanning beds in the past?	Yes	No
Do you currently use tanning beds?	Yes	No

OVER ⇨

Where were you raised? _____

Do you wear sunscreen daily? Yes No

For activities? Yes No

Tobacco Use? Current Daily Current Sometimes Former smoker Never smoker

Start date (year) _____ End date (year)_____

Date of last physical exam? (if none, please write none). _____

Height _____ Weight _____

Current Medications: _____

_____

Medication Allergies:_____

Non- Medication Allergies: Latex__ Others (IV dye, food, tape, etc) _____

Do you regularly take aspirin? Yes No

Preferred pharmacy (and location): _____

***Women only**:*

Date of last gynecologic exam: _____

Currently taking birth control pills: Yes No

Currently pregnant: Yes No

Signature_____ Date_____