UDC

University Dermatology Center

New Patient History Forms

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Transplantation
Cancer _____
COPD
Pacemaker
Lupus
Defibrillator
MRSA
Coronary Artery CAD
Depression
Diabetes
Kidney Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
Allergies
Blood Clots
HIV/AIDS
High Cholesterol
Thyroid Problems
Radiation Treatment
Seizures
Stroke
Tuberculosis
Leg Ulcers

NONE

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Eczema
Dry Skin
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Basal Cell Skin Cancer
Blistering Sunburns

NONE

Other: _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy
Colectomy
Gallbladder Removed
Coronary Artery Bypass
Heart Valve Replacement
Heart Transplant
Joint Replacement, Knee
Joint Replacement, Hip
Kidney Removed
Kidney Transplant
Ovaries Removed
TURP (Prostate Removal)
Spleen Removed
Testicles Removed
Hysterectomy:

NONE

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Do you require antibiotics prior to a surgical procedure? Yes No
Are you pregnant or currently trying to get pregnant? Yes or No

Medications: (Please enter all current medications or give copy of list to staff)
_____
_____
_____

Allergies: (Please enter all allergies)
_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

How did you hear about us?

Billboard
Employee
Event
Facebook
Family/Friend
Insurance
Internet/Website
Newspaper
Radio
Referring Provider
TV
Other: _____