THE DERMATOLOGY AND SKIN CANCER CLINIC OF ALASKA, P.C.

Patient _____ Date: ___/___/____ Chart # _____

Reason for today's visit: _____

Have you ever had dental anesthesia (Novocain)? ☐ Yes ☐ No Any bad reaction? ☐ Yes ☐ No

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, & herbs):

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

List all known allergies (including prescriptions, over-the counter meds, plastic and/or adhesives)

1. _____ 2. _____ 3. _____

Do you have or have you ever had any of the following diseases or conditions: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Chronic Cough	☐	☐

Cardiovascular:	YES	NO
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Irregular Heart Beat	☐	☐
Phlebitis	☐	☐
Inflammation of Vein	☐	☐
Blood Clots	☐	☐
Pacemaker	☐	☐
Rheumatic Fever	☐	☐
Artificial Heart Valve	☐	☐
Artificial Joints	☐	☐

Location/Age of Joint: _____

Gastrointestinal:	YES	NO
Hepatitis	☐	☐
Liver Disease	☐	☐
Diabetes	☐	☐

Other Systemic:	YES	NO
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐
Frequency/Burning	☐	☐
Arthritis/Joint Deformity	☐	☐
Fainting	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
Yeast infection when taking antibiotics	☐	☐

Neurological:	YES	NO
Stroke/TIA	☐	☐
Seizure Disorder	☐	☐
Cancer (other than skin)	☐	☐

Location _____

List any other diseases or conditions: _____

List any surgical procedures that you have had in the last 6 months: _____

Have you ever been advised to take antibiotics before surgery? ☐ YES ☐ NO

If yes, why? _____ Which antibiotic? _____

Do you take any blood thinners? (aspirin, vit E, coumadin or any other prescription blood thinner) ☐ YES ☐ NO

If yes: _____

Skin

Have you ever had skin cancer? ☐ YES ☐ NO

If yes what type _____ Location _____ Treatment given _____

Has anyone in your family had skin cancer? ☐ YES ☐ NO

Do you have a history of any specific skin disease? ☐ YES ☐ NO

Do you have problems with healing? ☐ YES ☐ NO

Do you develop keloids (scars) after surgery? ☐ YES ☐ NO

Do you bleed easily? ☐ YES ☐ NO

Do you develop skin rashes in reaction to ☐ Medications ☐ Food ☐ Environment? _____

Social History:

Do you drink alcohol? ☐ YES ☐ NO If yes, how many drinks per day? _____

Do you/have you used IV drugs? ☐ YES ☐ NO If yes, what? _____ How often? _____

Do you smoke? ☐ YES ☐ NO If yes, how much? _____

Do you have or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO

What is your occupation? _____ Hobbies? _____

(Women) Are you pregnant? ☐ YES ☐ NO Due Date: ___/___/____

Completed by: _____ Date: ___/___/____ *MA Initials* _____