SOUTHEAST DERMATOLOGY, P.A. **DATE:**___________________________

PATIENT NAME:___________________________________ **Pharmacy Name:** _________________________
DATE OF BIRTH:___________________________________ **Pharmacy Zip:**___________________________
Pharmacy phone #:_________________________

Past Medical History: (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial joints	End Stage Renal Disease	Lymphoma
Asthma	GERD (Reflux Disease)	Pacemaker
Atrial fibrillation	Hearing Loss	Prostate Cancer
Benign Prostate Hypertrophy	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV/AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD	Hyperthyroidism	None
Coronary Artery Disease	Hypothyroidism	

Other____

Past Surgical History: (please circle all that apply)

Appendix Removed (Appendectomy)	Joint Replacement, Knee (R, L, Both)	Prostate Biopsy
Bladder Removed (Cystectomy)	Joint Replacement, Hip (R, L, Both)	Prostate Cancer
Mastectomy (Right, Left, Bilateral)	Joint Replacement with past 2 years	Prostate: TURP (transurethral resection)
Lumpectomy (Right, Left, Bilateral)	Kidney Biopsy	Rectum: APR (abdominoperineal resection)
Breast Biopsy (Right, Left, Bilateral)	Kidney Removed (Nephrectomy)	Rectum: Low Anterior Resection
Colon Cancer Resection	Kidney Stone Removal	Skin Biopsy
Colon: Diverticulitis	Kidney Transplant	Skin: Basal Cell Carcinoma
Colon: Inflammatory Bowel Disease	Liver Removed (Hepatectomy)	Skin: Melanoma
Colon: Colostomy	Liver Transplant	Skin: Squamous Cell Carcinoma
Gallbladder Removed (Cholecystectomy)	Liver: Shunt	Spleen Removed (Splenectomy)
Heart: Coronary Artery Bypass	Ovaries: Endometriosis	Testicles Removed (Orchiectomy)
Heart: PTCA/Stent	Ovarian Cancer	Uterus: Fibroids
Heart: Biological Valve Replacement	Ovaries: Tubal Ligation	Uterus: Uterine Cancer
Heart: Mechanical Valve Replacement	Pancreas Removed (Pancreatectomy)	Uterus: Cervical Cancer
Heart Transplant		None

Other____

Skin Disease History: (please circle all that apply)

Acne	Blistering Sunburns	Melanoma
Actinic Keratoses	Dry Skin	Precancerous Moles
Asthma	Eczema	Psoriasis
Basal Cell Skin Cancer	Flaking or Itchy Scalp	Squamous Cell Skin Cancer
Other______________________	Hay Fever/Allergies	None

Do you have a family history of melanoma? Yes No If yes, which relative(s)?_______________________
Any other family history:____

Medications: (please enter all current medications)

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Allergies: (please enter all allergies)

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Social History: (please circle all that apply)

Cigarette smoking:	Never smoked	Quit: former smoker	Current: every day	Current: some days
Alcohol use:	None	< 1 drink per day	1-2 drinks per day	3 or more drinks per day

Occupation and Workplace: ____