WELLESLEY DERMATOLOGY CARE

MEDICAL PATIENT INFORMATION

Patient Name: _____ **D.O.B.:** _____ **Date:** _____

ALLERGIES ☐ None, or: _____

CURRENT MEDICATIONS ☐ None, or: _____

Pharmacy Name: _____ **City:** _____ **State:** _____ **Zip:** _____

Pharmacy Address: _____ **Phone:** _____

Primary Care Physician: _____ **Who recommended this visit?** _____

Reason for today's visit: _____ **When did the problem begin?** _____

Which areas are involved? _____

Please check all that apply: ☐ Itchy ☐ Painful ☐ Bleeding ☐ Getting Better ☐ Getting Worse

What treatments were tried? _____ Did the treatments help? _____

Would you like a skin check / total body screening examination today *(time permitting)*? ☐ Yes ☐ No

Current medical problems: ☐ None, or:

Past medical problems or surgeries:

Please check all that apply:

MY HEALTH

- ☐ Fevers
- ☐ Headaches
- ☐ Joint Pain
- ☐ Bleeding Problems
- ☐ Pregnancy
- ☐ Planning Pregnancy
- ☐ Anxiety
- ☐ Depression
- ☐ Other Mental Health Concerns

MY SKIN HISTORY

- ☐ Psoriasis
- ☐ Eczema
- ☐ Acne
- ☐ Atypical Moles
- ☐ Multiple Sunburns
- ☐ History of Blistering Sunburn(s)
- ☐ Skin Cancer

Type if Known: _____

FAMILY HISTORY

- ☐ Psoriasis
- ☐ Eczema
- ☐ Acne
- ☐ Melanoma
- ☐ Atypical Moles
- ☐ Skin Cancer - *Who:* _____

MY HABITS

Do you wear sunblock? ☐ Yes *SPF:* _____ ☐ No

Circle One (if Applicable): Daily **OR** When at the Beach

Ever used a tanning booth? ☐ Yes ☐ No

Number of Times (Approx.): _____

Do you drink alchohol? ☐ Yes ☐ No

Drinks Per Week: _____

Do you smoke? ☐ Yes ☐ No

ABOUT ME

Do you live alone? ☐ Yes ☐ No

If no, who lives with you? _____

Occupation *(Including Caregiver, Homemaker)*:

_____

Hobbies / Leisure Activities:

_____