DERMATOLOGY HISTORY

Name __________________________________________________________ Date ____________________
Occupation ___________________________________________________________ Age __________________

CC & HISTORY OF PRESENT ILLNESS

<table>
<thead>
<tr>
<th>List your skin problems</th>
<th>Their Location</th>
<th>How Long</th>
<th>Treatment</th>
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MEDICATIONS

What medicines do you take? (include aspirin, laxatives, birth control pills, vitamins, creams, etc.)

ALLERGIES

Are you allergic to latex? □ YES □ NO
Are you allergic to any medicines? □ YES □ NO
If so, what? ________________________________
Are you allergic to local anesthesia? □ YES □ NO

MEDICAL HISTORY  □ YES □ NO

Do you require antibiotics before dental procedures? □ YES □ NO
Do you bleed easily? □ YES □ NO
Are you pregnant? □ YES □ NO

SKIN HISTORY

Have you had pre-cancer? □ YES □ NO
Have you had a skin cancer? □ YES □ NO
Have you had a melanoma (cancer in a mole)? □ YES □ NO
Has a sunburn ever caused water blisters? □ YES □ NO
Is so, where on the body? ________________________________
Have you had a skin disease in the past? □ YES □ NO
If so, what? ________________________________

FAMILY HISTORY

Has anyone in your family had skin cancer? □ YES □ NO
If so, who? ________________________________
Has anyone in your family had a melanoma? □ YES □ NO
If so, who? ________________________________
Has anyone in your family had a skin disease in the past? □ YES □ NO
If so, what? ________________________________

SOCIAL HISTORY

Do you smoke? □ YES □ NO
Do you drink alcohol? □ YES □ NO

REVIEW OF SYSTEMS

PLEASE CHECK IF YOU HAVE:

□ Anemia
□ Arthritis
□ Cancer
□ Diabetes
□ Liver Disease
□ Tuberculosis
□ High Blood Pressure
□ Thyroid Disease
□ Kidney Disease
□ Heart Disease
□ Asthma/Hay Fever
□ Other Health Problems

PLEASE DO NOT USE REVERSE SIDE