Denver Dermatology Consultants, P.C.

Name _____ Date _____

Date of Birth _____ Pt. # _____

In order to treat you safely and effectively, please answer the following questions:

ALLERGIES to medication(s): No___ Yes ___ (please specify) _____

_____

Type of reaction_____

List of MEDICATIONS and WHAT ARE YOU TAKING THE MEDICATIONS FOR *(please include over the counter medications, vitamins, birth control, herbal supplements, topicals). If none, write none:*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you take Aspirin, Plavix, Pradaxa or Coumadin? If so what are you taking the medication for?

_____

_____

_____

_____

YOUR Medical History *(Check all that apply)*

_____ Melanoma
_____ Squamous Cell Carcinoma (location)
_____ Basal Cell Carcinoma (location)
_____ Skin cancer- not sure what type
_____ Allergies or Hay Fever
_____ Asthma
_____ Autoimmune Disorder
_____ Bleeding Disorders
_____ Blood Clots
_____ Depression/Anxiety
_____ Diabetes- Which type?
_____ Difficulty healing after surgery
_____ Eczema
_____ Exposure to someone with Tuberculosis (TB)
_____ Heart Attack/Stroke
_____ Hepatitis- Which Type?
_____ High Blood Pressure
_____ High Cholesterol
_____ History of positive PPD or Tuberculosis (TB)
_____ HIV
_____ Hives
_____ Kidney Disease
_____ Liver Problems
_____ Lung Disorder
_____ Migraines/Headaches
_____ Neurological Disorder
_____ Pneumonia
_____ Psoriasis
_____ Thyroid Problems- Which Type?
_____ Unexpected weight loss/gain

List any other MEDICAL PROBLEMS:

_____

_____

_____

_____

_____

_____

Please turn over and complete back side of form →

List any SURGERIES: _____
_____
_____
_____

Do you have any immediate family members with skin cancer or history of skin cancer? ____ No ____ Yes
If yes, which family member and what type of skin cancer?_____
_____

Do you have any artificial joints, heart valve or a pacemaker?
No ____ Yes_____ (please specify) _____

Do you take antibiotics prior to dental or surgical procedures? No ____ Yes ____

Do you use tobacco products? No_____ Yes_____ Type/frequency_____

Do you drink alcohol? No_____ Yes_____ How much? _____

Do you use recreational drugs? No_____ Yes_____ *Type/frequency*_____
(including marijuana products) _____

FOR FEMALES:
Are you currently pregnant? No_____ Yes_____
How many weeks? _____

Are you breast feeding? No_____ Yes_____

Date of last menstrual period _____

Do you have normal menstrual cycles? _____

Have you had ovarian cysts? _____

_____ _____
Signature *Date*

Reviewed by: _____