PALM BEACH DERMATOLOGY

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PATIENT UPDATE

Patient Name _____Date of Birth_____Date_____

Email Address_____Primary Care Physician_____Phone_____

Reason for your visit today_____

Medications you are allergic to_____

Describe reaction you had_____

Medications you are currently taking, including over the counter medications, multivitamins, birth control, blood thinners, and hormone therapy_____

_____

_____

Check any of the following conditions you have:

☐ High Blood Pressure ☐ Heart Attack ☐ Chest Pain ☐ Valve Replacement ☐ Pacemaker ☐ Irregular or Fast Heart Beat

☐ Other Heart Problems _____

☐ Breathing Problems ☐ Asthma ☐ List any other lung problems_____

☐ Kidney Disease ☐ Diabetes ☐ Hepatitis ☐ Blood Transfusions ☐ HIV/AIDS ☐ Artificial Joints

☐ Seizures ☐ Arthritis ☐ Radiation Treatment

List any other surgeries, hospitalizations, or medical problems you have had_____

_____

Do you presently use Sunscreen? ☐ Yes ☐ No If yes, what SPF Number?_____

Have you had any of the following?

☐ Skin Cancer ☐ Melanoma ☐ Precancers ☐ Sun Sensitivity ☐ Blistering Sunburn ☐Allergies ☐ Eczema

☐ Psoriasis ☐ Acne ☐ Poison Ivy ☐ Itchy Flaking Scalp ☐ Dry Skin ☐ Hay fever

Have you ever had difficulty stopping bleeding? ☐ Yes ☐ No

Do you require antibiotics PRIOR to any surgical or dental procedure? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No Or currently planning to become pregnant? ☐ Yes ☐ No

Has anyone in your family had any of the following?

☐ Eczema ☐ Allergies ☐ Hay fever ☐ Asthma ☐ Acne ☐ Skin Cancer ☐ Melanoma ☐ Sun Sensitivity ☐ Psoriasis

What is your occupation?_____

Have you had any occupational sun exposure or radiation exposure? ☐ Yes ☐ No

Have you had any occupational arsenic or petrol products exposure? ☐ Yes ☐ No

Where were you born?_____Number of years in Florida_____

Do you smoke? ☐ Yes ☐ No If yes, how much?_____

Do you drink beer, wine or liquor? ☐ Yes ☐ No If yes, how much?_____

Check any of the following that apply to you now or have in the past?

☐ Chicken Pox ☐ Shingles ☐ Tuberculosis ☐ HIV/AIDS ☐ Urinary Infection ☐ Asthma ☐ Emphysema

☐ Bronchitis ☐ Pleurisy ☐ Shortness of Breath ☐ Ulcer ☐ Colitis ☐ Gallstones ☐ Bloody Stool

☐ Persistent Vomiting ☐ Bloody Urine ☐ Stroke ☐ Difficulty Urinating ☐ Prostate Problems

☐ Hearing Loss ☐ Paralysis ☐ Loss of Strength ☐ Glaucoma ☐ High Cholesterol ☐ High Triglyceride