OnSite DERMATOLOGY
Convenient Skin Care and Treatment Services

PLEASE COMPLETE AND BRING WITH YOU TO APPOINTMENT

Date: _____/_____/_____Reason for today's visit:_____

Patient name: _____ Phone #_____

Community Name: _____ Date of Birth:_____/_____/_____

Primary Insurance: _____ ID # _____

Secondary Insurance: _____ ID # _____

Are you allergic to any medications? YES NO If yes, list below:

1._____2._____

List all medications you are currently taking

_____

_____

_____

_____

Please circle to answer choice

Past Medical History – Do you have any history of:

Hypertension:	Yes No	Keloid scarring:	Yes No
Heart Disease:	Yes No	Problems with healing:	Yes No
Diabetes:	Yes No	Eczema:	Yes No
Asthma/COPD:	Yes No	Psoriasis:	Yes No
Arthritis:	Yes No	Atypical moles:	Yes No
Pacemaker:	Yes No	HIV positive:	Yes No
Artificial valves:	Yes No	Hepatitis C positive:	Yes No
Cancer:	Yes No	Problems with anesthesia:	Yes No

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Patient name: _____

Skin Cancer History

Pre skin cancer:	Yes	No
Basal Cell Carcinoma:	Yes	No
Squamous Cell Carcinoma:	Yes	No
Malignant Melanoma:	Yes	No

Family History

Family hx of skin cancer:	Yes	No
Family hx of melanoma:	Yes	No
Family hx of other skin diseases:	Yes	No

Surgical History

Artificial hip joint:	Yes	No
Artificial joint:	Yes	No

Social History

Alcohol Consumption: Never Occasionally Frequently (every day)

Smoking Status: Current Everyday Some Days Former Smoker Never

Sunscreen use: Yes No At least 1 blistering sunburn: Yes No

Did you get your flu shot this year? Yes No

Did you get you pneumonia shot this year? Yes No

Any other information you would like us to know:

_____

_____

_____

_____

www.onsitederm.com

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