School Street Dermatology

Medical Information

Today's Date: **Please Answer All Questions** **Please print**- black ink only

Patient's Name:_____ **Date of Birth:**_____

Reason for today's visit (Complaint or Diagnosis, if known):_____

Medications/Treatments you have used for this current problem:_____

_____

Pharmacy (name, city, state):_____

Medications, please list any and all including vitamins and herbal supplements:

Include frequency and dose if known:_____

_____

_____

Allergies (list reactions):_____

Do you or anyone in your family have a history of melanoma? Y/N *(please circle)* **If yes, who?**

_____

Please *circle* if you have/have had the following:

Anxiety	Arthritis	Asthma	Irregular Heartbeat	Bone Marrow Transplant	
BPH	Cancer other than skin		Skin Cancer	COPD	CAD
Depression	Diabetes		End Stage Renal Disease	GERD	Hearing Loss
Hepatitis	HIV/AIDS	Hypercholesterolemia		Thyroid Issues	Leukemia
Radiation	Seizures	Stroke	Issues with healing/ scarring/ bleeding		

What is your current smoking status? *(please circle)* **Current/Former/Never**

Have you received a flu shot this flu season? *(please circle)* **Y/N**

Have you *ever* received the pneumonia vaccine?) Y/N

Do you have a health care proxy? *(please circle)* **Y/N**

If yes, who?_____

Our privacy policy is located in the waiting room for you to read. If you would like a copy please ask the receptionist.