WASATCH DERMATOLOGY

Compassion. Tradition. Excellence.

Patient:____Date of Birth:___/___/ ___ Today's Date________________

Reason for today's visit:____

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

____

Have you ever had dental anesthesia (Novocaine)? ❑ YES ❑ NO Any bad reaction? ❑ YES ❑ NO

List all medications you are currently taking (including prescriptions, over-the-counter medications, vitamins and herbals):

*(List additional medications on back)*____

____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑

Cardiovascular:	YES	NO
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of vein	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	YES	NO
Diabetes	❑	❑
Excessive thirst/hunger	❑	❑
Amputation	❑	❑
Thyroid Kidney	❑	❑
Dialysis	❑	❑
Bladder	❑	❑
Frequency/burning	❑	❑
Gastrointestinal		
Stomach absorptive disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthralgia	❑	❑
Limited motion	❑	❑
Artificial joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting		

List any other diseases or conditions:____

List surgical procedures you have had in the last 6 months:____

Skin:

When you are exposed to the sun do you: ❑Tan Only ❑ Tan and burn ❑ Burn
Has anyone in your family had skin cancer? ❑ YES ❑ NO
Do you have a history of any specific skin diseases? ❑ YES ❑ NO
Do you have problems with healing? ❑YES ❑ NO
Do you develop keloids (scars) after surgery? ❑ YES ❑ NO
Do you develop skin rashes in reaction to: ❑ Medications ❑ Food ❑ Environment ❑ Bandages ❑ Neosporin ❑ Other

Social History:

Do you drink alcohol? ❑ YES ❑ NO If YES_______drinks per day
Do you use IV drugs? ❑ YES ❑ NO If YES, what? _______How often? __________
Do you smoke? ❑ YES ❑ NO If YES, how much?
Have you had or have you been exposed to HIV? (AIDS) ❑ YES ❑ NO

Please answer the following questions:

A. Do you bleed easily? ❑ YES ❑ NO
B. (Women) Are you pregnant? ❑ YES ❑ NO Due Date: ____/____/
C. What is your occupation? ____
D. What are your hobbies? ____

Completed by: Patient ____
Signed by Patient or Responsible Party Date

Medical Assistant _________ ____
Initials Reviewed By Date

WASATCH
DERMATOLOGY
Compassion. Tradition. Excellence.

Patient:

Date of Birth: ______ /______ /

Please list any additional medications you are taking here: