Name_____ Date of Birth_____ Date_____

Reason to be seen:_____
Symptoms: (circle) irritated itch pain bleeding growing changing
How long have you had these problems?_____
Have you seen another doctor for your current skin problem? ___ yes ___ no
Please explain:_____
What did not work?_____
What helped?_____
What medications or other creams do you apply to your skin problems?_____

Please check if you now have or have ever had diseases or conditions of:

__ Blood Disorders
__ Blood Pressure
__ Bones or Joints
__ Breathing (Asthma, Hay Fever etc.)
__ Circulation (Phlebitis etc.)
__ Convulsions
__ Eyes (Glaucoma etc.)
__ Kidneys/Bladder
__ Have or been exposed to HIV (AIDS)
__ Glands (Thyroid, Diabetes etc.)
__ Hearing
__ Heart (Murmur, Angina etc.)
__ Infections (T.B. etc)
__ Liver (Hepatitis etc.)
__ Mouth
__ Stomach, bowel

Who do you live with?_____
Do you drink alcohol? ___ yes ___ no If so, how much? _____
Do you use recreational drugs? ___ yes ___ no

Do you have or have you had eczema, psoriasis, skin cancer, or other skin problems? ___ yes ___ no
Please explain:_____
Does a relative have eczema, psoriasis, skin cancer or other skin problems? ___ yes ___ no
Please explain:_____

Do you have unusual reactions to medications or injections (such as fainting)? ___ yes ___ no
Please explain:_____

Reviewed by: _____ Date _____