SOUTHVIEW DERMATOLOGY

JANET J CASH, MD
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NAME_____ BIRTHDATE_____

ADDRESS _____

PHONE: HOME ( )_____ WORK: ( )_____ CELL: ( )_____

EMAIL:_____

MALE __ FEMALE __ HEIGHT _____ WEIGHT (patient reported)_____ ETHNICITY _____

PHARMACY _____ PHONE#_____ FAX# _____

MAIL ORDER PHARMACY _____

PAST MEDICAL HISTORY/PROBLEM LIST:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Do you have a history of any specific skin disease? YES NO

If yes, please list _____

Are you currently receiving any treatment for any specific skin disease? YES NO

If yes, please list any treatment including the name of the physician treating you and any medications you are currently using for the skin disease (Prescription, over the counter, or herbal).

_____

Do you bleed easily? YES NO

Do you have AIDS or have you ever been exposed to HIV/AIDS? YES NO

Are you pregnant or breastfeeding? (women only) YES NO

PREVIOUS SURGERIES/INJURIES (and date) _____

_____

DRUG ALLERGIES _____

FOOD/ENVIRONMENT ALLERGIES (if yes, list any known food or environmental factors that produce rashes).

_____

MEDICATIONS: NAME/DOSE/HOW IT'S TAKEN NAME/DOSE/HOW IT'S TAKEN

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING?

Asthma	YES	NO	Relationship _____
Eczema/Atopic Dermatitis	YES	NO	Relationship _____
Excessive Hair Growth	YES	NO	Relationship _____
Hay Fever	YES	NO	Relationship _____
Hereditary Hair Loss	YES	NO	Relationship _____
Melanoma	YES	NO	Relationship _____
Non-melanoma skin cancer	YES	NO	Relationship _____
Psoriasis	YES	NO	Relationship _____
Severe Acne	YES	NO	Relationship _____
Other Hereditary Skin Disease	YES	NO	Relationship _____

If yes, please list _____

SOCIAL HISTORY ____ Single ____ Married ____ Divorced ____ Widowed

CHECK ALL THAT APPLY

Living With

___ Spouse
___ Children
___ Extended family
___ Significant Other
___ Foster Care
___ Live alone
___ Assisted Living
Other _____

Tobacco Use

___ Never Smoked
___ Former Smoker
___ Current Smoker
___ Cigarettes ___ packs per day
___ Pipe ___ Cigars
___ Smokeless Tobacco
___ Chewing Tobacco
___ Snuff

Alcohol Use

___ Never
___ Social/Occasional
___ Daily
___ Former Drinker
___ Recovering Alcoholic

Addictive Drugs

___ Never Use
___ Former User
___ Regular use of Narcotic Pain Relievers
___ Amphetamines (other than for ADHD)
___ Diet Pills
___ Cocaine

SUN EXPOSURE

___ Past history of excessive sun exposure/burning ___ Tan only ___ Tan and burn ___ Burn
___ Outdoor Occupation
___Regularly tan in sun-recreational
___Tanning bed use ___Former occasional ___Former regular ___Current occasional ___Current regular

Occupation _____ Hobbies _____

Forms completed by:
__ Patient ___Parent/Guardian ___Medical Assistant __ Nurse ___Other _____(relationship)

Patient Signature _____ Date _____

Parent/ Guardian Signature_____ Date _____

Physician Signature _____ Date