Denver Tech Dermatology Associates PC

Patient name _____ Date_____
Date of Birth_____
Primary Care Physician: _____
How did you hear about us? _____
Reason for today's visit_____
_____
Do you have any medication allergies?
_____
List prescription medications you take:
_____
_____
List over-the-counter medications you take:
_____
Do you have any allergies to the following? If so, please mark the appropriate boxes:
☐Latex ☐lidocaine ☐Adhesive/band-aids ☐Iodine ☐Shellfish

Mark any skin conditions you have a history of or currently have:
☐ Psoriasis ☐ Autoimmune disease ☐ Eczema ☐ Hives ☐ Hay fever ☐ Asthma ☐ Atypical moles
☐ Actinic Keratoses ☐ Basal cell cancer ☐ Squamous cell cancer ☐ Melanoma ☐ Arthritis

List other skin conditions not mentioned above: _____

Do you have any of these? If so, please mark the appropriate boxes:
☐ Pacemaker ☐ Defibrillator ☐ Joint implants ☐ Heart valve disease ☐Solid organ transplant
☐ Bone marrow transplant ☐ HIV infection ☐ History of hepatitis ☐Bleeding disorder
☐Keloidal scarring ☐Take blood thinners ☐History of blood clots ☐ Heart murmur
Do you need pre-medication antibiotics for dental work or surgery? _____

Do you have any of these disorders? If so, please mark the appropriate boxes:
☐Eye disease ☐Kidney disease ☐Liver disease ☐Coronary artery disease ☐High blood pressure
☐Thyroid disorder ☐Diabetes Type 1 ☐ Diabetes Type 2 ☐Seizures ☐High cholesterol ☐Stroke
List other medical conditions not mentioned above:
_____

List any surgeries requiring general anesthesia:_____
_____

Mark any symptoms that apply to you:

☐ Unexplained fever ☐Drenching night sweats ☐ Unexplained weight change ☐Fatigue ☐ Joint pain

☐ Chronic cough ☐ Chest tightness ☐ Chest pain ☐Headaches ☐Varicose veins ☐Abdominal pain

☐Diarrhea ☐Irregular heart beat ☐Lower extremity swelling ☐ Depression ☐Other_____

When you are exposed to the sun do you:

☐ always burn; extremely sun sensitive?

☐ burn easily; then tan a little?

☐ tan slowly; sometimes burn?

☐ always tan; burn a little?

☐ tan well; rarely burn?

☐ never burn?

Do you have photosensitivity (sensation of burning on your skin when exposed to sunlight)?_____

Do you have any first-degree relatives with a history of melanoma?_____
Do any first-degree relatives have skin conditions? If so, what kind? _____
Do any first-degree relatives have auto-immune conditions (ex: lupus, rheumatoid arthritis, thyroid disorders)? _____

Do you wear sunscreen on your face daily? _____
Have you ever used a tanning bed? _____If so, how many times have you tanned indoors in your lifetime? _____ Do you still use tanning beds? _____
Have you ever had a blistering or painful sunburn? _____

What is/was your occupation? _____
What are your hobbies? _____
Do you drink alcohol? _____ If yes, how many drinks per day? _____
Do you smoke cigarettes/vape? _____ If yes, how many times per day? _____
Do you smoke or ingest pot?_____ Do you use illicit drugs?_____

Women only:
Are you on any form of oral, injectable or implantable contraceptives? _____
Are you pregnant or trying to become pregnant? _____Are you nursing? _____

Pharmacy Information:

Name and zip code: _____

_____ _____
Patient Signature Date