SOUTHVIEW DERMATOLOGY

JANET J. CASH, MD

CHANTE K. AKSUT, MD

NAME: ____**BIRTHDATE**_________________________

ADDRESS: ____

PHONE: ***HOME:*** **(   )**_______________***WORK*****: (   )**____________________***CELL*****: (   )**______________________

Sex_____ **Male**_____ **Female**______ **Height**_________ **Weight**_________ **Patient Reported**_______________

PHARMACY:____

PHARMACY PHONE # (   )_________________________________**FAX# (   )**_______________________________

MAIL ORDER PHARMACY:____

PAST MEDICAL HISTORY/PROBLEM LIST:

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________
6. ____________________________________
7. ____________________________________
8. ____________________________________
9. ____________________________________
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 (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: **YES** **NO** **(women only)**

PREVIOUS SURGERY/INJURIES (and date):____

____

DRUG ALLERGIES: ____

FOOD /ENVIRONMENT ALLERGIES: (*If yes, please list any known food or environmental factors that produce rashes)*

____

MEDICATIONS: NAME/DOSE/HOW IT'S TAKEN REASON FOR TAKING

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

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

YES /NO	Asthma	Relationship______________
YES/NO	Eczema/Atopic Dermatitis	Relationship_____________
YES/NO	Excessive Hair Growth	Relationship_____________
YES/NO	Hay Fever	Relationship_____________
YES/NO	Hereditary Hair Loss	Relationship______________
YES/NO	Melanoma	Relationship_____________
YES/NO	Non-melanoma skin cancer	Relationship_____________
YES/NO	Psoriasis	Relationship______________
YES/NO	Severe Acne	Relationship______________

Other Hereditary Skin Disease Relationship______________

If yes, please list:____________________________________

SUN EXPOSURE HISTORY:

___Tan only _____Tan and Burn ____Burn

TANNING BED USE HISTORY:

___ Former occasional

___ Former regular

___Current occasional

___ Current regular

___ Outdoor Occupation

___ Regularly Tan in sun-recreational

SOCIAL HISTORY: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

(Check all that apply)

Living with	Tobacco Use	Alcohol Use	Addictive Drugs
____Spouse	____Never Smoked	____Never	____Never used
____Children	____Former Smoker	____Social/Occasional	____Former user
____Extended family	____Current Smoker	____Daily	____Regular use of Narcotic Pain Relievers
____Significant other	____Cigarettes ____packs per day	____Former Drinker	____Amphetamines (other than for ADHD)
____Foster Care	____Pipe ____Cigars	____Recovering Alcoholic	_____Diet Pills
____Live alone	____Smokeless Tobacco		____Cocaine
____Assisted Living	____Chewing Tobacco		
Other____________	____Snuff		

Occupation: ___________________________ Hobbies_____________________________________

Forms completed by:

Patient/Guardian________________

Medical Assistant________________

Nurse__________________________

Signature: ____ Date: ____/____/____

Physician: ____ Date: ____/____/____