PRESIDIO DERMATOLOGY

Patient Name:_____ **Age:**_____

Referred by:_____

**** Preferred Pharmacy:**_____

Reason for today's visit:

Past Medical History
(May skip if provided online/ZocDoc)

History of skin cancer: **yes/no**
(If yes, what type, location on body, when)**:**

Family history of skin cancer: **yes/no**
(If yes, what type and in whom):

Tanning bed history: **yes/no** **past/present**
Smoking tobacco history: **yes/no** **past/present**
Chewing/snuff tobacco history: **yes/no** **past/present**

Medical Conditions/History: **Medications:** **Drug Allergies:**

Are you experiencing:
Fevers/chills **yes/no**
Frequent infections or weakened immune system **yes/no**
Hay fever/seasonal allergies **yes/no**
Asthma **yes/no**
Irregular menstrual cycles **yes/no**
Are you pregnant/nursing/trying to conceive **yes/no**

Occupation:_____