

DERMATOLOGY HEALTH HISTORY

Name: _____ DOB: _____ Date: _____

Reason for visit today: _____

Medications (including prescription, over the counter, vitamins, herbals, etc.) _____

Medication allergies: _____

Non-medication allergies: Latex ? Lidocaine? Other? _____

History of Skin Cancer: basal cell carcinoma squamous cell carcinoma melanoma none

Have you had suspicious looking moles removed in the past? Yes No

Have you had precancers (actinic keratoses) frozen with liquid nitrogen previously? Yes No

Have you done home treatment with Efudex or Carac? Yes No

Have you had photodynamic therapy for precancers? Yes No

Medical History: (please circle all that apply)

Anemia	Glaucoma	High cholesterol	Pacemaker
Arthritis	Hay fever / allergies	HIV	Rheumatologic disease
Artificial joint	Healing difficulties	Keloids / thick scars	Thyroid disease
Asthma	Heart failure	Kidney disease	
Bleeding or clotting issues	Heart murmur	Lung infections	Other cancer:
Depression/ anxiety	Hepatitis	Lupus	_____
Diabetes	Herpes (cold sores)	Neurologic disease	_____
Eczema	High blood pressure	Psoriasis	_____

Do you have a family history of melanoma? Yes No

Do you wear sunscreen daily? Yes No

Do you wear a hat and /or protective clothing? Yes No

Do you work outdoors? Yes No

Would you like to discuss your skin care regimen or cosmetic treatments? Yes No

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