TRI-CITY DERMATOLOGY

112 Columbia Point Drive, Suite 105
Richland, WA 99352
Tel: (509) 873-7140
Fax: (509) 818-1303

PATIENT HISTORY

(PLEASE PRINT)

Please complete the following sections, to the best of your knowledge, concerning your current or past medical history.

CURRENT OR PAST MEDICAL CONDITIONS

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Cancer (type): _______________
☐ COPD
☐ Coronary Arteriosclerosis
☐ Depressive disorder
☐ Diabetes mellitus
☐ End stage renal disease
☐ Epilepsy
☐ GERD
☐ Heart Disease
☐ Hepatitis C
☐ High Blood Pressure
☐ High cholesterol
☐ HIV/AIDS
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Leukemia
☐ Liver Disease
☐ Radiation treatment
☐ Stroke
☐ Other Medical Conditions: ____

PRIOR SURGERIES

☐ Appendix
☐ Bladder
☐ Brain
☐ Breast
☐ Colon
☐ Gallbladder
☐ Heart
☐ Joint Replacement: ____________
☐ Kidney
☐ Ovaries
☐ Pancreas
☐ Prostate
☐ Testicles
☐ Uterus
☐ Other Surgeries: ____

SKIN CONDITIONS

☐ Acne
☐ Actinic Keratosis (pre-cancer)
☐ Dry Skin
☐ Eczema
☐ Flaking or Itching Scalp
☐ Psoriasis
☐ Warts or other growths
☐ Skin Cancer: Basal Cell
☐ Skin Cancer: Melanoma
☐ Skin Cancer: Squamous Cell
☐ Other: ____

Do you wear sunscreen? ☐ Daily ☐ Sometimes ☐ No SPF? ________

Have you used a tanning bed? ☐ No ☐ Past ☐ Current (how often?): __________________

Do you have a family history of melanoma? ☐ No ☐ Yes, please indicate whom: _________________________

CURRENT MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER)

____

____

____

____

____

Columbia Point Drive, Suite 105
Richland, WA 99352
Tel: (509) 873-7140
Fax: (509) 818-1303

PATIENT HISTORY cont.

KNOWN DRUG ALLERGIES

____

____

ADDITIONAL QUESTIONS

Do you use tobacco products? ☐ No ☐ Past ☐ Current (please circle type): Cigarettes Tobacco

Do you drink alcohol? ☐ No ☐ Yes (how many per week?): _________________

Female patients only: are you pregnant or planning to become pregnant? ☐ No ☐ Yes

PATIENTS 65 AND OLDER

Have you received a pneumonia vaccination? ☐ No ☐ Yes, Date: _________________

Do you have an advance directive or living will? ☐ No ☐ Yes: ____

Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No

PLEASE IDENTIFY A FAMILY HISTORY OF ANY OF THE FOLLOWING

☐ Skin Cancer__________	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ Other Cancer_________	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ Eczema	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ Heart Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ Lupus/Auto Immune Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ Psoriasis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ Sarcoidosis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son

PLEASE CHECK ALL THAT APPLY

☐ Allergy to adhesive
☐ Allergy to lidocaine
☐ Allergy to topical antibiotics
☐ Artificial heart valve
☐ Artificial joints within past two years
☐ Blood Thinners
☐ Defibrillator
☐ Hay fever

☐ Headaches
☐ Immunosuppressants
☐ Joint aches
☐ MRSA
☐ Muscle weakness
☐ Night sweats
☐ Pacemaker
☐ Pregnant or planning pregnancy

☐ Premedication prior to procedures
☐ Problems with bleeding
☐ Problems with healing
☐ Problems with scarring/keloids
☐ Rapid heartbeat with epinephrine
☐ Unintentional weight loss

☐ Other: ____