Advanced Dermatology of Oregon TODAY'S DATE ___/___/___

NAME: LAST_____FIRST_____MIDDLE_____
AGE: _____ DATE OF BIRTH: ___/___/___ SS#: _____-_____-_____
TELE (H): (____)_____TELE (W): (____)_____TELE (CELL): (____)_____
EMAIL:_____
EMERGENCY CONTACT (NAME, RELATION, TELE): _____
REFERRING PHYSICIAN (NAME, ADDRESS, PHONE):_____
PHARMACY (NAME, ADDRESS, PHONE): _____

CURRENT MEDICATIONS (prescription & over the counter):

ARE YOU TAKING ASPIRIN, MOTRIN, ADVIL, COUMADIN, OR VITAMIN E? **YES NO**

ALLERGIES TO MEDICATIONS (list all esp. antibiotics, pain medications, latex, lidocaine, tapes, ointments,etc..)

OCCUPATION: _____ GENERAL HEALTH: GOOD FAIR POOR
DO YOU SMOKE? YES NO IF YES, HOW MANY PACKS PER DAY? _____
DO YOU DRINK ALCOHOL? YES NO IF YES, HOW MANY DRINKS PER DAY? _____
DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING?

HIGH BLOOD PRESSURE	YES	NO	*ARTIFICIAL JOINTS	YES	NO
STROKES	YES	NO	ARTHRITIS	YES	NO
HEART ATTACK/FAILURE	YES	NO	*HEPATITIS	YES	NO
IRREGULAR HEART BEAT	YES	NO	*HIV	YES	NO
CARDIAC PACEMAKER	YES	NO	*EASY/PROLONGED BLEEDING	YES	NO
*HEART VALVE PROBLEM *ARTIFICIAL HEART VALVE	YES YES	NO NO	*BLOOD TRANS-FUSIONS/PRODUCTS	YES	NO
SEIZURES/EPILEPSY	YES	NO	RECENT SURGERY	YES	NO
TROUBLE BREATHING/LUNG PROBLEMS	YES	NO	INTERNAL CANCER: TYPE:_____	YES	NO
EYE PROBLEMS (eg. GLAUCOMA)	YES	NO	NERVE PROBLEMS	YES	NO
EARS/NOSE/THROAT PROBLEMS	YES	NO	ORGAN TRANSPLANT	YES	NO
GASTROINTESTINAL PROBLEMS	YES	NO	*DIFFICULT HEALING	YES	NO
GENITAL/URINARY PROBLEMS	YES	NO	*SCARS/KELOIDS	YES	NO
CIRCULATION PROBLEMS	YES	NO	OTHER HEALTH PROBLEMS (LIST):	YES	NO
DEPRESSION/ANXIETY/PSYCHIATRIC PROBLEMS	YES	NO			

Do you take antibiotics before dental procedures? **YES NO**
Do you have questions about cosmetic dermatology? **YES NO**
DO YOU OR ANY OF YOUR *BLOOD* RELATIVES HAVE A HISTORY OF?

DISEASE (CIRCLE & MARK "X")	ME	RELATIVE	NO	DON'T KNOW
DIABETES OR THYROID PROBLEMS				
LUPUS/AUTOIMMUNE PROBLEMS				
MELANOMA/OTHER SKIN CANCERS				
ASTHMA/HAYFEVER/ALLERGIES				
ECZEMA/ PSORIASIS				
INTERNAL CANCERS: TYPE				

Questions re: COSMETIC DERMATOLOGY: **YES NO**

OK TO LEAVE VOICE MAIL FOR LAB & BIOPSY RESULTS @ TELE # _____ **YES NO**
OK TO EMAIL BIOPSY RESULTS, ANNOUNCEMENTS & REMINDERS **YES NO**
OK TO TELL FAMILY MEMBERS RESULTS, NAME:_____ **YES NO**
FOR WOMEN:
Are you pregnant, nursing, taking birth control pills, or hormones? **YES NO**
Plan to become pregnant? **YES NO**

_____ _____
Patient/Guardian Signature Date