BURKE DERMATOLOGY

Patient Name: _____ D.O.B: _____
Address: _____ City:_____ State: ____
Email: _____

PAST MEDICAL HISTORY:
Personal history of cancer other than skin_____

__Anxiety	__COPD	__High Blood Pressure	__Thyroid Issues
__Arthritis	__ Depression	__Inflammatory Bowel Disease	__Radiation Treatment
__Asthma	__ Diabetes	__Organ Transplant, Type:_____	__Stroke
__Eczema	__Psoriasis	__Hay Fever	__Heart Disease

Other Medical History not listed:_____

HISTORY OF SKIN DISEASE:
Personal History of Skin Cancer? __Basal Cell Carcinoma __Squamous Cell Carcinoma __Melanoma
DO YOU HAVE A FAMILY HISTORY OF MELANOMA? Relative(s):_____

MEDICATION: Check here if you have an attached list _____
Please include dosage and strength if known _____
_____
_____

Patient Height: _____ Patient Weight: _____ (Required for prescriptions)

ALLERGIES:_____
_____

SOCIAL HISTORY: Do you smoke? __Yes __No Do you drink alcohol? __Yes __No

ALERTS:

__Allergy to Adhesive	__On Blood Thinners/Aspirin	__MRSA
__Allergy to Lidocaine	__History of Fever Blisters	__Seizures
__Allergy to Latex	__Pacemaker	__Kidney disease
__Allergy to Iodine	__Defibrillator	__C-Diff
__Artificial Joint	__HIV/AIDS	__Pregnant or trying to get pregnant
__Artificial Heart Valve	__Hepatitis B	__Breast Feeding
__Allergy to Oral Antibiotics	__Hepatitis C	__Neurostimulator/implantable device
__Requires Antibiotics prior to procedure		

Pharmacy Name:_____ Pharmacy Address: _____
Primary Care Physician:_____

Do you authorize our clinic to discuss your medical information with family members, including biopsy results, lab results, office notes and other test results? Yes/No Who _____

Do you authorize our clinic to leave a detailed voicemail, text, and/or email? Yes/No

SIGNATURE:_____ DATE:_____