WASHINGTON SQUARE DERMATOLOGY

DOROTHY J. CUNNINGHAM, MD, FAAD

PATIENT NAME: _____ **TODAY'S DATE:** ____ /____ /____

DATE OF BIRTH: _____ / _____ / _____ **OCCUPATION:** _____

PREFERRED PHARMACY (NAME AND PHONE NUMBER, IF KNOWN):_____

PRIMARY CARE PHYSICIAN (NAME AND PHONE NUMBER, IF KNOWN): _____

Preferred language: _____

RACE:
White
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
Other Race

ETHNIC GROUP:
Hispanic or Latino
Not Hispanic or Latino
Unknown

PAST MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other: _____

PAST SURGICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other: _____

Over →

SKIN DISEASE HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other: _____

Do you wear Sunscreen? Yes No **If yes, what SPF? _____**
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No **If yes, which relative(s)? _____**

Do you have a family history of other skin diseases? If yes, please explain: _____

CURRENT MEDICATIONS:

_____
_____
_____
_____

ALLERGIES:

_____
_____
_____
_____

SOCIAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

Please answer only the questions you feel comfortable having in your permanent medical record

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Safety:
- I feel safe at home.
- I do not feel safe at home.

Illicit Drug Use:
- Drug Use
- IV Drug Use

Sexual History:
- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same sex partner

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

REVIEW OF SYSTEMS: ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY)

Problems with bleeding
Problems with healing
Problems with scarring (hypertrophic or keloid)
Rash
Immunosuppression
Hay fever
Chest pain
Fever or chills
Night sweats
Unintentional weight loss
Thyroid problems
Sore throat
Blurry vision
Abdominal pain
Bloody stool
Nausea
Bloody urine
Joint aches, muscle weakness
Neck stiffness
Headaches
Seizures
Cough, shortness of breath, wheezing
Anxiety
Depression

Other Symptoms: _____

ALERTS: ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY)

Allergy to adhesive
Allergy to lidocaine
Allergy to topical antibiotic ointments
Artificial heart valve
Artificial joints within past two years
Blood thinners
Defibrillator
MRSA
Pacemaker
Premedication prior to procedures
Rapid heartbeat with epinephrine
Pregnancy or planning a pregnancy

Other Symptoms: _____