

Alamance Skin Center

1734 Westbrook Ave
Burlington, NC 27215
Phone (336)584-5801 Fax (336)584-5860

Chart # _____

Patient Medical History Sheet

Date _____

Name _____

Age _____ Male or Female (circle) Birthdate _____

Name of doctor who sent you here (if applicable) _____

Your Past Medical History

Previous skin cancer? Yes No

Basal Cell Carcinoma? Yes No

Squamous Cell Carcinoma? Yes No

Previous melanoma? Yes No

If yes, describe location and other information you know about your melanoma. _____

Other cancers? Yes No

If yes, please list other cancers: _____

Have you had extensive sun exposure? Yes No

How many blistering sunburns have you had? _____

Fever Blisters? Yes No

Keloids or abnormally thick scars? Yes No

Asthma? Yes No

Seasonal Allergies? Yes No

Eczema? Yes No

Psoriasis? Yes No

Diabetes? Yes No

High Blood Pressure? Yes No

Heart Disease? Yes No

Other medical conditions? Yes No

If yes, please list other medical conditions: _____

Other surgery? Yes No

If yes, please list surgeries and indicate year: _____

Your Family History

What diseases run in your family? Family member(s) or relative(s) with condition:
If yes, describe and indicate relative(s):

Melanoma? Yes No _____

Other skin cancer? Yes No _____

Psoriasis? Yes No _____

Eczema? Yes No _____

Seasonal allergies? Yes No _____

Asthma? Yes No _____

Skin Disease? Yes No _____

Others?(list) Yes No _____

Your Social History

Are you working now? Yes No

What is (or was) your occupation?

Do you smoke? Yes No

Approximately how many drinks of alcohol do you consume in a week? _____

Drug Allergies:

(please describe reaction)

Medication List:

Over→

Name _____
 Chart# _____

Review of Systems

Please circle yes or no and
 Describe medical condition or symptoms:

General Health

Fever	Yes	No	_____
Chills	Yes	No	_____
Weight Loss	Yes	No	_____
Fatigue	Yes	No	_____

Describe

Skin

Eczema	Yes	No	_____
Psoriasis	Yes	No	_____
Hives	Yes	No	_____
Sun sensitivity	Yes	No	_____

Describe

Eyes

Vision Changes	Yes	No	_____
Dry eyes	Yes	No	_____
Cataracts	Yes	No	_____

Genital/Urinary

Kidney Disease	Yes	No	_____
Urinary Symptoms	Yes	No	_____
Female/Male Diseases	Yes	No	_____

Ear/Nose/Throat/Mouth

Earache	Yes	No	_____
Nosebleeds	Yes	No	_____
Sore Throat	Yes	No	_____
Mouth Ulcers	Yes	No	_____
Fever Blisters	Yes	No	_____

Blood/Lymphatic

Bleeding Tendency	Yes	No	_____
Blood Clots	Yes	No	_____
Swollen Glands	Yes	No	_____

Respiratory

Shortness of Breath	Yes	No	_____
Cough	Yes	No	_____
Asthma	Yes	No	_____

Muscle/Bones

Muscle/Joint Aches	Yes	No	_____
Weakness	Yes	No	_____
Arthritis	Yes	No	_____

Neurologic

Headaches	Yes	No	_____
Dizziness	Yes	No	_____
Numbness/Tingling	Yes	No	_____

Endocrine

Thyroid Disease	Yes	No	_____
Diabetes	Yes	No	_____

Psychiatric

Depression	Yes	No	_____
Anxiety	Yes	No	_____
Other	Yes	No	_____

Cardiovascular

Heart Disease	Yes	No	_____
Stroke	Yes	No	_____
Atherosclerosis	Yes	No	_____

COSMETIC INTEREST QUESTIONNAIRE

At Alamance Skin Center, we provide all of the below cosmetic services. Please review and check any and all of the below health issues of interest to you.

BOTOX® Cosmetic (Botulinum Toxin Type A)
 Collagen or Restylane or other "fillers" to fill in wrinkles
 Skin rejuvenation
 Avage, Retin A, or Renova
 Antioxidant skin treatments (Vitamin C&E)
 Micro-Dermabrasion
 Chemical peels/Acid Peels
 Laser treatments
 Liposuction
 Acne

Skin care advice
 Skin care products
 Birthmarks
 Liver spots/age spots
 Sunscreen advice
 Removing leg veins
 Facials and eye treatments
 Hair removal (laser hair removal)
 Spider vein treatments
 Removing facial veins
 Other, please specify: _____

HOW DID YOU HEAR ABOUT US?

Physician (full name) _____
 My insurance company provider _____
 The yellow pages (specify advertisement) _____
 A friend or family member (name) _____
 Another person not listed above (name) _____
 An article or advertisement in _____
 Internet
 A seminar where I saw the doctor. The event took place on (date): _____
 at (location): _____