Alamance Skin Center
Partnering for exceptional care.
1734 Westbrook Ave. • Burlington, NC 27215

Height _____ Weight_____

Patient Medical History Sheet

Date _____

Name _____

Age _____ Male or Female (circle) Birthdate _____

Name of doctor who referred 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? If yes, describe and indicate relative(s): — Family member(s) or relative(s) with condition:

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? _____

Current Tobacco Use? Yes No
Current Electronic Cigarette Use? Yes No

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

Do you tan in a tanning bed? Yes No If yes, how often? _____

Drug Allergies:

(please describe reaction)

_____
_____
_____
_____
_____
_____

Medication List:

_____
_____
_____
_____
_____
_____
_____
_____

Over→

Review of Systems

Name: _____
Patient ID#: _____

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

General Health			Describe
Fever	Yes	No	_____
Chills	Yes	No	_____
Weight Loss	Yes	No	_____
Fatigue	Yes	No	_____

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

Ear/Nose/Throat/Mouth			
Earache	Yes	No	_____
Nosebleeds	Yes	No	_____
Sore Throat	Yes	No	_____
Mouth Ulcers	Yes	No	_____
Fever Blisters	Yes	No	_____

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

Endocrine			
Thyroid Disease	Yes	No	_____
Diabetes	Yes	No	_ _____

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

Gastrointestinal			Describe
Crohn's	Yes	No	_____
Irritable bowel	Yes	No	_____
Reflux	Yes	No	_____
Other	Yes	No	_____

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

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

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

Psychiatric			
Depression	Yes	No	_____
Anxiety	Yes	No	_____
Other	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)
- ☐ Juvéderm, Voluma, Restylane, Vollure, Volbella or other "fillers" to fill in wrinkles
- ☐ Skin rejuvenation
- ☐ Acne
- ☐ Micro-Dermabrasion
- ☐ Chemical peels/Acid Peels
- ☐ Laser treatments
- ☐ Removing facial veins
- ☐ Spider vein treatments
- ☐ 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)
- ☐ Other, please specify: _____

HOW DID YOU HEAR ABOUT US?

- ☐ Physician (full name) _____
- ☐ My insurance company provider _____
- ☐ 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): _____

Revised: 4/19/2019