

DERMATOLOGY INFORMATION SHEET

Patient's Name: _____ Today's Date: _____

Family Physician: _____ Referred By: _____

Approximate Duration of Hair loss: _____

Has anyone else in your family had a similar problem? _____

Are you allergic to any medications? _____

If so, which ones? _____

What medications are you taking now? _____

Have you taken aspirin, aspirin-containing medications, or blood thinners in the last ten days? _____ If so, which ones? _____

Do you have a history of a bleeding problem? _____ If so, what type? _____

Is there a family history of skin cancer? _____ If so, what relatives and, if known, what type of skin cancer? _____

Do you have any history of moles that have gotten larger, darker, that get irritated by the sun, or have bled? _____

Do you have any specific questions you wish to have answered? _____

DERMATOLOGY INFORMATION Continued

Do you have a history of any of the following: (Circle either yes or no)

Diabetes	Yes	No	Heart Disease	Yes	No
High Blood Pressure	Yes	No	Heart Murmur	Yes	No
Lung Disease	Yes	No	Heart Valve Replacement	Yes	No
Cancer	Yes	No	Pacemaker	Yes	No
Collagen Vascular Diseases	Yes	No	Heart Surgery	Yes	No
Rheumatoid Arthritis	Yes	No	Liver Disease	Yes	No
Lupus	Yes	No	Joint Replacement	Yes	No
Tobacco Use	Yes	No	Alcohol Use	Yes	No
Drug/Narcotic Habit	Yes	No	Excessive Alcohol Habit	Yes	No

If yes to any except smoking and moderate alcohol, please give brief explanation:

Do you have a history of Hepatitis or HIV infection? _____

Do you have a history of exposure to tuberculosis or positive TB test? _____

Please list any surgeries you have had in the past five years: _____

Please list any other significant health problems: _____

What was the date of your last physical examination? _____