

BLOOMFIELD DERMATOLOGY

NAME: _____

BIRTH DATE: _____ AGE: _____

HOME ADDRESS: _____

HOME PHONE: _____

CITY: _____

CELL PHONE: _____

STATE / ZIP: _____

WORK PHONE: _____

OCCUPATION: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN: _____

WHO REFERRED YOU TO THIS OFFICE: _____

Pharmacy Name: _____	Pharmacy Number: _____
Current Medications: _____ _____	
Allergies to Medications: (Circle) Penicillin Sulfa Erythromycin Any Others: _____	
Other Allergies: (Circle) Latex Adhesives Foods: _____ Cosmetic Products: _____ Any Others: _____	

Reason for your visit today: _____

- Skin Check Change in Mole Rash Warts Acne
 Other, please explain: _____
 Cosmetic Procedure: (Check) Botox / Dysport Spider Veins Peels Fillers Fraxel Laser

Personal History:

Have you ever had skin cancer? Yes / No If yes what type: _____

Family history of skin cancer? Yes / No (Circle): Basal cell Squamous cell Melanoma

Any other type of cancer? Yes / No If yes what type: _____

Psoriasis	Yes / No	Inflammatory Bowel Disease	Yes / No
Eczema or Atopic Dermatitis	Yes / No	Kidney Disease	Yes / No
Hay fever, Asthma or Hives	Yes / No	HIV / AIDS	Yes / No
High Blood Pressure	Yes / No	Bleeding Disorder	Yes / No
Heart Disease	Yes / No	Stomach Ulcers	Yes / No
Stroke / TIA	Yes / No	Tuberculosis	Yes / No
Diabetes	Yes / No	Lupus, Raynaud's, Scleroderma or	Yes / No
Liver Disease / Hepatitis / Jaundice	Yes / No	other Rheumatologic Disease	Yes / No

Any Others Diseases: _____

Do you smoke? _____ How many glasses of Alcohol or Beer a week? _____

Have you ever been advised to take antibiotics before a procedure (such as dental work)? Yes / No

Do you take aspirin or blood thinners? Yes / No

Have you ever had Blood or Plasma transfusion? Yes / No

List any surgery you have had: _____

Patient's Signature: _____ **Date:** _____