Florida Dermatology AND SKIN CANCER CENTERS

PATIENT MEDICAL RECORDS

The doctors and staff of Florida Dermatology and Skin Cancer Centers are pleased that you have chosen us for your health care needs. Please complete this form so that we may better serve you. The information you provide will assist us in attending to your healthcare needs more effectively and efficiently. It is important that you provide us with any changes or updates (address, insurance company, medication changes, etc.) For more information about the products and services we offer, please speak with a staff member.

Patient:_____ Date:_____

Reason for Today's Visit:_____

Do you have now, or have you ever had diseases or conditions of: ***(If yes, please check box)***

Lungs: [ ] Bronchitis [ ] Emphysema [ ] Asthma [ ] Chronic Cough [ ] Morning Cough [ ] COPD

Vascular: [ ] High Blood Pressure [ ] Chest Pain [ ] Heart Attack [ ] Heart Murmur [ ] Stroke

[ ] Irregular Heartbeat [ ] Pacemaker [ ] Blood Clot/ Phlebitis [ ] Mitral Valve Prolapse

Other Systemic: [ ] Diabetes [ ] Thyroid [ ] Kidney [ ] Bladder [ ] Stomach [ ] Bowel [ ] Glaucoma

[ ] Hepatitis A/B/C [ ] Arthritis/ Joint

Current Medication	Y / N	If yes, please list
Do you have any allergies to food or medication?	[ ] [ ]	_____
Do you currently use any prophylactic antibiotics?	[ ] [ ]	_____
Do you currently drink alcohol?	[ ] [ ]	Amt per day: _____
Do you currently use IV drugs?	[ ] [ ]	If yes, what_____ Amt per day:_____
Do you currently take any mediation? (Use back of sheet, if necessary)	[ ] [ ]	Please list_____
Have you ever been exposed to HIV/AIDS?	[ ] [ ]	Have you ever had a blood transfusion? Y [ ] N [ ]
Ever had dental anesthesia (Novacaine)?	[ ] [ ]	Any Adverse Reaction? Y [ ] N [ ]
Are you latex intolerant?	[ ] [ ]	

Skin	Y / N	
Have you ever had skin cancer?	[ ] [ ]	If yes, location(s)_____
Family history of skin cancer?	[ ] [ ]	Relationship (s)_____
Do you currently use skin care products?	[ ] [ ]	If yes, what_____

When exposed to the sun, do you [ ] Tan [ ] Tan and Burn [ ] Burn

List any other disease or condition we should be aware of:_____

List surgical procedures performed within the last six months:_____

Please answer the following questions:

A. Do you smoke? Y [ ] N [ ] B. Former smoker? Y [ ] N [ ] C. Do you have artificial joints, pins, or screws? Y [ ] N [ ]

D. Do you require antibiotics prior to surgery? Y [ ] N [ ] E. (Women) Are you pregnant? If no, date of last menstrual period:_____

Preferred Pharmacy:_____ Location:_____ Phone #:_____

Completed by: Patient [ ]_____ (initial) Nurse [ ]_____ (initial)