Norris Dermatology and Laser Northwest

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Board Certified Dermatologist
Physician & Surgeon

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Certified Physicians Assistant

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

1. PURPOSE OF TODAY'S VISIT?

a. *When did it begin?*

b. *What treatments have been tried and were they helpful?*

c. *What makes it better?* *What makes it worse?*

2. ALLERGIES:

_____ No known drug allergies
_____ Antibiotics (Penicillin, Sulfa, etc)
_____ Xylocaine
_____ LATEX
_____ Other _____

3. MEDICATIONS: Please include vitamins/supplements/topical products

Name of Medication	Dose per day	Start Date	Reason for taking

4. MEDICAL HISTORY: Please list all PAST and PRESENT medical problems:

1. Skin Cancer (when, where and how treated) _____
2. _____
3. _____
4. _____
5. _____

5. SKIN HISTORY: Please check all that apply to you.

_____Acne	_____Hayfever	_____Rosacea
_____Athlete's foot	_____Asthma	_____Pre-skin cancer
_____Nail problems	_____Eczema	_____Dandruff
_____Herpes simplex	_____Allergies	_____Autoimmune disease

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Please complete both sides ➔

Continuation of SKIN HISTORY: Do you have?

_____Hives _____Psoriasis _____Allergy to Nickel
_____Allergy to poison oak _____Allergy to iodine _____Allergy to tape/adhesives
_____Allergy to skin care/cosmetics: _____
_____Previous Patch Testing_____

6. SURGICAL HISTORY: Hospitalizations/Surgeries by DATE

_____
_____
_____

7. Where did you grow up? _____
How much sun exposure have you had? _____Minimal _____Moderate _____Extreme

8. SOCIAL HISTORY:

a. Are you a smoker? _____Former smoker_____ Current smoker_____ Never smoker
b. Do you drink alcohol? _____None_____ 1-7drinks/week_____ More than 7 drinks/week
c. Do you use sunscreen? _____yes _____Daily
d. Do you use a tanning bed? _____yes _____no _____Currently_____Past

9. REVIEW OF SYSTEMS:

_____Organ Transplant _____Artificial joints
_____Hepatitis _____Thyroid problems
_____HIV _____Chronic headaches
_____Bleeding Problems _____Pacemaker
_____Difficulty healing _____Scar/Keloid

10. FAMILY HISTORY: Skin cancer, psoriasis, eczema, diabetes, lupus, hair problems, etc.

Mother:
Father:
Brothers:
Sisters:
Children:

11. Are there any other aspects of your health not mentioned which you feel are important?

_____
_____

Please sign below:

_____ _____
Patient Signature Date