Patricia L. Norris, M.D.
Board Certified Dermatologist
Physician & Surgeon

PATIENT NAME: _____ **DOB:** _____

Drug/Skin Allergies:

- ☐ No known drug/skin allergies
- ☐ Antibiotics (Penicillin, Sulfa, etc.)
- ☐ Lidocaine
- ☐ Poison Oak
- ☐ Iodine
- ☐ Tape/Adhesives
- ☐ Latex
- ☐ Nickel
- ☐ Skin care/cosmetics: _____

Other: _____

Medications: Please include vitamins/supplements/topical products. ◇NONE

Name of Medication	Dose per Day	Start Date	Reason for Taking

Medical History: List all past and present medical problems: i.e. skin cancer (when, where, how treated)

a. _____
b. _____
c. _____
d. _____

Surgical/Hospitalization History with dates:

a. _____
b. _____
c. _____
d. _____

Skin History: Please check all that apply to you.

- ☐ Acne
- ☐ Athlete's foot
- ☐ Nail problems
- ☐ Herpes simplex
- ☐ Hay fever
- ☐ Asthma
- ☐ Eczema
- ☐ Rosacea
- ☐ Pre-skin cancer
- ☐ Dandruff
- ☐ Autoimmune disease
- ☐ Hives
- ☐ Psoriasis
- ☐ Other: _____

Where did you grow up? _____

How much sun exposure have you had? ☐ Minimal ☐ Moderate ☐ Extreme

Do you use sunscreen? ☐ Yes ☐ No ☐ Daily **Do you use a tanning bed?** ☐ Yes ☐ No ☐ Past

Review of Systems: Check all that apply to you.

- ☐ Organ transplant
- ☐ Hepatitis
- ☐ HIV
- ☐ Pacemaker
- ☐ Bleeding problems
- ☐ Difficulty healing
- ☐ Chronic headaches
- ☐ Artificial joints
- ☐ Thyroid problems
- ☐ Scar/Keloids

Family History: Skin cancer, psoriasis, eczema, diabetes, lupus, hair problems, etc.

Relation: _____ Condition: _____

_____ _____

_____ _____

PATIENT SIGNATURE: _____ **DATE:** _____