ALLURE DERMATOLOGY
Dermatology and Dermatologic Surgery

NAME _____ BIRTH DATE ___/___/___

PCP LETTER
_____

MEDICAL HISTORY:
PLEASE CHECK ANY OF THESE PROBLEMS YOU NOW HAVE OR HAVE HAD:

___ Asthma, emphysema
___ Hay fever
___ Eczema
___ Hives
___ Skin cancer
___ Other skin disease
___ Liver disorder
___ Hepatitis
___ Prostate problems
___ Stomach ulcer
___ Thyroid disease
___ Diabetes
___ Arthritis
___ Cancer
___ Tuberculosis
___ Stroke
___ Seizures
___ Fainting spells
___ Headaches
___ Nervous/emotional
___ Bleeding disorder
___ Anemia/blood disorder
___ Kidney/bladder problem
___ High blood pressure
___ Heart disease
___ Poor wound healing
___ Blood transfusions
___ Eye or ear disorder

WOMEN:
___ Vaginal infections
___ Presently pregnant
___ Menstrual problems
___ Last menstrual period

Please list all medications you are taking (including aspirin, birth control pills, laxatives, etc.): _____

_____

_____

Vitamins, herbs, supplements (dosages): _____

_____

Special diet: _____

_____

Are you allergic to any medication, food, clothing, metal, insect, etc.? ___ Yes ___ No

Please list them: _____

_____

Previous operations & year: _____

_____

_____

Personal history: Do you or did you:
___ Smoke ___ Drink alcohol ___ Work outdoors
___ Work with harmful chemicals
___ Spend a lot of recreational time in the sun (golf, fishing, etc.)

Family History:
___ Skin cancer ___ Allergies ___ Eczema ___ Psoriasis ___ Hay fever
___ Bleeding or clotting disorders

STAYS
LEAVES
WHERE
BACK

Any other problems or conditions we should know about? _____

_____