ALLURE DERMATOLOGY
Dermatology and Dermatologic Surgery

PCP LETTER ______

NAME ______ BIRTH DATE ___ / ___ / ___

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

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

WOMEN:

___ Vaginal infections ___ Menstrual problems
___ Presently pregnant ___ 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

Any other problems or conditions we should know about? ______

STAYS ______
LEAVES ______
WHERE ______
BACK ______