

# Metropolitan Dermatology

TO HELP US GIVE YOU THE BEST POSSIBLE CARE, PLEASE COMPLETE ALL QUESTIONS.

Do you take any medicine, drugs, or over-the-counter preparations or remedies? .....yes no  
If yes, please list: \_\_\_\_\_

Have **you** ever had or been treated for any of the following? (*Circle all that apply*)

- |                                       |                            |   |
|---------------------------------------|----------------------------|---|
| • Excessive sun exposure in childhood | • Psoriasis                | • Neurological disorder                         |
| • Sunburns                            | • Liver disease            | • Emotional or psychiatric problem              |
| • Melanoma                            | • Lung disease             | • Blood or lymph gland disorder                 |
| • Skin cancer                         | • Heart disease            | • Arthritis, joint problem or bone disease      |
| • Keloids or excessive scars          | • High blood pressure      | • Diabetes                                      |
| • Allergy to local anesthetics        | • Kidney disease           | • Ulcer or intestinal disease                   |
| • Excessive bleeding                  | • Venereal disease         | • Conditions requiring prophylactic antibiotics |
| • Difficulty with the healing         | • Cancer (other than skin) |   |

Other conditions (please specify) \_\_\_\_\_

Have you previously had a skin problem or been under the care of a dermatologist? (If yes, please describe) \_\_\_\_\_

Are you **ALLERGIC** to any medicines, drugs, or over-the counter preparations or remedies? .....yes no  
If yes, please list \_\_\_\_\_

Prior hospitalization or surgery (Please specific surgery and dates) \_\_\_\_\_

Have any members of your **family** had, specify who: (*Circle all that apply*)

- |  |                                   |
|--|-----------------------------------|
| • Asthma                                       | • Psoriasis                       |
| • Hay fever                                    | • Melanoma                        |
| • Eczema                                       | • Skin cancer other than melanoma |
| • Other skin conditions (please specify) _____ |                                   |

Are you single, married, partnered, divorced, legally separated, widowed? \_\_\_\_\_

Have you ever been exposed to HIV, hepatitis B, C, or D viruses? .....yes no  
If yes, please circle all that apply.

\*Smoking status: (*Please circle one*)

Current every day smoker, current some day smoker, former smoker, never smoked.

\*Do you drink alcohol? .....yes\* no

\*If yes, how often did you have six or more drinks on one occasion in the past year? (*Please circle one*)

*Never, less than monthly, monthly, weekly, or daily/almost daily.*

\*If yes, how many drinks did you have on a typical day when you were drinking in the past year? (*Please circle one*)

*1 or 2, 3 or 4, 5 or 6, 7 to 9, or 10+*

\*If yes, how often did you have a drink containing alcohol in the past year? (*Please circle one*)

*Never, monthly or less, two to four times/month, two to three times/week, 4+ times/week*

\*Please note these questions are asked to comply with U.S. Government requirements.

## **~For Women Only**

~Are you pregnant, planning a pregnancy or nursing? \_\_\_\_\_

~Do you have regular menstrual periods? ..... yes no

**NOTE:** THE DERMATOLOGICAL EXAMINATION WHICH YOU ARE ABOUT TO RECEIVE IS NOT A COMPLETE PHYSICAL EXAMINATION. IT IS SUGGESTED THAT YOU HAVE A COMPLETE PHYSICAL EXAMINATION PERIODICALLY BY YOUR FAMILY PHYSICIAN OR INTERNIST.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_