Tideway Dermatology, PA
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Patient name: _____ Date: _____
Occupation: _____

Past Medical History: (please circle all that apply)

Anxiety	GERD	Other _____
Arthritis	Hearing Loss	_____
Asthma	Hepatitis	_____
Atrial fibrillation	Hypertension	
BPH	HIV/AIDS	
Bone Marrow Transplantation	Hypercholesterolemia	
Breast Cancer	Hyperthyroidism	
Colon Cancer	Hypothyroidism	
COPD	Leukemia	
Coronary Artery Disease	Lung cancer	
Depression	Lymphoma	
Diabetes	Seizures	
End Stage Renal Disease	Stroke	

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Breast surgery: Lumpectomy (Right, Left, Bilateral) / Breast Biopsy (Right, Left, Bilateral) / Mastectomy (Right, Left, Bilateral) / Breast Reduction / Breast Implants
Colectomy: (Due to): Colon Cancer Resection Diverticulitis IBD
Coronary artery bypass
Gallbladder Removed
Heart Transplant
Heart valve Replacement: Date: _____ Mechanical Valve Replacement / Biological Valve Replacement
Joint Replacement: Knee (Right, Left, Bilateral) Date(s) of replacement: _____
Joint Replacement: Hip (Right, Left, Bilateral) Date(s) of replacement: _____
Kidney: Biopsy / Kidney Removed (Right, Left) / Kidney Stone Removal / Kidney Transplant
Lung: Biopsy / Removed (right/left) / Transplant (date) _____
Ovaries: Cyst / Endometriosis / Ovarian Cancer / Ovaries removed (date) _____
Pacemaker
PTCA
Prostate: Biopsy / Cancer / Removed (date) _____
Radiation Treatment: site and date: _____
Skin: Biopsy/ Basal Cell Cancer Surgery / Squamous Cell Carcinoma Surgery / Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
TURP
Uterus: Hysterctomy due to: fibroids / uterine cancer
Other surgical history: _____

****PLEASE TURN FORM OVER AND COMPLETE BACK OF FORM****

Skin Disease History: (please circle all that apply) Patient name: _____

Acne
Actinic keratosis
Asthma
Basal cell skin cancer
Blistering sunburns
Dry skin
Eczema
Flaking or itchy scalp
Hay fever/Allergies
Melanoma
Poision Ivy
Precancerous moles
Psoriasis
Squamous cell skin cancer

Do you wear Sunscreen? Yes / No If yes, what SPF? _____ Do you tan in a tanning salon? Yes / No

Do you have a family history of melanoma? Yes / No If yes, which family member? _____

Do you have a family history of high blood pressure? Yes / No. If yes, which family member? _____

Social History: (Please circle all that apply)

Alcohol Use: (circle one): none / less than 1 drink a day / 1-2 drinks a day / 3 or more drinks a day
Cigarette Smoking: (circle one): Never smoked / former smoker (quit) / smokes less than daily / smokes daily
Drug Use(circle one): never / current / history IV Drug Use (circle one): never / current / history

Other_____

MEDICATIONS AND ALLERGIES: (please list all current medication/dose/how often you take the medication)

Current Medications:_
MEDICATION NAME: DOSE: FREQUENCY:
_____
_____
_____
_____
_____
_____

Current Allergies(please list name of medication/what type of reaction you had/how many years ago)
MEDICATION NAME: WHAT TYPE OF REACTION?: WHEN?"
_____
_____
_____
_____

WHAT IS THE REASON FOR YOUR VISIT TODAY?_____