Brookline Village Dermatology, P.C.

Patient Name: ___________________________________**Date of Birth:** ___________ **Today's Date**: ____________

May we leave a message, containing private medical information? Yes _____ No_____
May we speak a family member regarding private medical information? Yes _____ No_____
Home voicemail/answering machine? Yes____ No____ Cell phone? Yes ____No____ Work phone? Yes____ No ____
Best phone number for the office to leave a message (_____) _____-_____ or (_____) _____-_____

List all Allergies: (*Write NONE, if none)*____
List all Current Medications: *(Write NONE, if none)* ____
____

Reason for Today's Visit: (*include duration of problem and previous treatments)*_______________________________
____
____

Any Past Skin Problems: (*Circle all that apply)* •skin cancer • **melanoma** • childhood blistering sunburns • psoriasis • eczema . Details:____
____
____

List All Surgeries and Operations: *(Write NONE, if none)* ____
____
____

Current or Past Problems with:

	YES	NO	Explain if YES		YES	NO	Explain if YES
General Health	☐	☐	____________	Arthritis/Muscles/Joints	☐	☐	____________
Eyes	☐	☐	____________	Headaches/Seizures	☐	☐	____________
Ears/Nose/Throat/Mouth	☐	☐	____________	Psychological Disorder	☐	☐	____________
Heart	☐	☐	____________	Thyroid/Diabetes	☐	☐	____________
Lungs	☐	☐	____________	Blood/Bleeding Disorder	☐	☐	____________
Stomach/Bowels	☐	☐	____________	Allergic/Immunologic	☐	☐	____________

Do you have any joint replacements or heart valves? *(If NO, write no)*_______________________________
Do you take antibiotics prior to dental procedures? (*If NO, write no*)_______________________________

Females: • Are you pregnant? ___Yes ____No •Planning to become pregnant? ____Yes ____No
Family History: (Past Family and Social History)
•Mother: living or deceased of __________at age____ •Father: living or deceased of ___________at age____
•Number of children: _______ age(s): ______________________

Check the following medical conditions that have occurred in your family:

DISEASE	Mother	Father	Blood Relative
Allergies/hayfever/asthma	☐	☐	☐
Arthritis	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Eczema	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Malignant Melanoma	☐	☐	☐
Psoriasis	☐	☐	☐
Skin Cancer	☐	☐	☐
Tuberculosis	☐	☐	☐

Social History
Do you use sunscreens? ___No___Daily___Sometimes
Do you drink alcohol? ___No___Yes ___Occasionaly
Occupation: _______________________________
Do you smoke? ___No___Yes
Hobbies/Leisure activities__________________________
____

Reviewed_______________________________**Date**_______________ **Updated**_______________
(MD Signature)
Updated_____________ **Updated**______________