ROBBINS Dermatology P.C.

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Name _____ **Birthdate** ____ / _____ / _____

Height _____ **Weight** _____

All Medications/Supplements
(or attach list)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medication Allergies

_____

_____

_____

_____

Your Medical History

Skin Cancer **Yes / No**
Other Cancer **Yes / No**
Type _____
Hepatitis **Yes / No**
Diabetes **Yes / No**
High Blood pressure **Yes / No**
Heart problems **Yes / No**
Pacemaker **Yes / No**

Other Medical Problems:

_____

Surgeries:

_____

Family History

Skin Cancer / Eczema
Psoriasis / Acne
None of the above
Other

Who _____

Social History

Occupation _____

Who do you live with?

_____

Smoker **Current / Former / Never**

Alcohol **Yes / No**

Skin History

Radiation treatments **Yes / No** Reason _____
History of blistering burns **Yes / No**
Tanning bed use **Past / Present / Never**
Sunscreen user **Yes / No**

System Review - Please circle your current symptoms

Chest pain / Poor circulation / Leg Swelling

General Health: Good / Fair / Poor

Fever / Loss of appetite / Night Sweats /

Weakness / Weight Change

Changing lesions / Dry Skin / Itching / Rash

Sores in Nose / Sores in Mouth / Dry Mouth

Nasal Congestion / Difficulty Swallowing

Hearing Loss / Nose Bleeds / Abdominal Pain /

Constipation / Diarrhea / Back Pain

Muscle Weakness / Joint Pain / Muscle Pain

Dizziness / Headaches / Burning in Hands or Feet

Change in Vision /Dry or Itchy Eyes / Anxiety

Depression / Cough / Shortness of Breath / Wheezing

_____ _____

Patient signature Date MD signature Date