

BOULDER  
*Dermatology*

PATIENT NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_

PLEASE ANSWER THE FOLLOWING QUESTIONS IN DETAIL

PLEASE CIRCLE THE APPROPRIATE ANSWER:

1. HAVE YOU EVER BEEN TREATED FOR: STOMACH ULCERS TUBERCULOSIS LUNG DISEASE  
HIGH BLOOD PRESSURE KIDNEY DISEASE LIVER DISEASE HIV/AIDS SUBSTANCE ABUSE  
DIABETES THYROID DISEASE HEPATITIS C  
IF YES, EXPLAIN IN DETAIL: \_\_\_\_\_

2. HAVE YOU OR ANY BLOOD RELATIVE HAD ASTHMA HAY FEVER ECZEMA? WHO? \_\_\_\_\_

3. DO YOU SMOKE? YES NO HOW MANY PER DAY? \_\_\_\_\_

4. DO YOU CONSUME ALCOHOL? YES NO HOW MUCH? \_\_\_\_\_

5. DO YOU USE ILLEGAL/RECREATIONAL SUBSTANCES? \_\_\_\_\_

6. DO YOU HAVE A PACEMAKER, A HEART PROBLEM SUCH AS A HEART MURMUR, ARTIFICIAL  
JOINTS, OR VEINS WHICH REQUIRE YOU TO TAKE ANTIBIOTICS BEFORE SURGERY? YES NO

7. HAVE YOU EVER HAD BLEEDING PROBLEMS (POOR CLOTTING) OR ABNORMAL SCARRING WHEN  
CUT (KELOIDS)? YES NO DESCRIBE: \_\_\_\_\_

8. DO YOU HAVE A PERSONAL HISTORY OF SKIN CANCER? YES NO IF YES, WHAT TYPE?  
BASAL CELL CARCINOMA SQUAMOUS CELL CARCINOMA MELANOMA UNKNOWN

9. DO YOU HAVE A FAMILY HISTORY OF SKIN CANCER? YES NO IF YES, WHAT TYPE?  
BASAL CELL CARCINOMA SQUAMOUS CELL CARCINOMA MELANOMA UNKNOWN

10. HAVE YOU EVER HAD ANY SERIOUS ILLNESSES NOT MENTIONED ABOVE? \_\_\_\_\_

11. DO YOU HAVE ANY DRUG ALLERGIES? YES NO IF SO, PLEASE LIST \_\_\_\_\_

12. ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATIONS, OVER THE COUNTER  
MEDICINES, AND/OR HERBAL PRODUCTS? YES NO IF YES, PLEASE LIST \_\_\_\_\_

CURRENT SKIN PROBLEMS

1. DESCRIBE YOUR CURRENT SKIN PROBLEM: \_\_\_\_\_

2. WHEN DID IT BEGIN? \_\_\_\_\_

3. WHAT CURRENT OR PAST TREATMENTS HAVE YOU HAD FOR THIS PROBLEM (INCLUDING ANTIBIOTICS,  
CREAMS, ETC.)? \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_