

# Arcadia / Sun Lakes Dermatology

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Past Medical History:** (please circle all that apply)

- Anxiety
- Arthritis
- Artificial joints
- Asthma
- Atrial fibrillation
- BPH
- Bone Marrow Transplantation
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- Hypertension
- HIV/AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Pacemaker
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- Valve Replacement
- None

Other

\_\_\_\_\_  
\_\_\_\_\_  
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**Past Surgical History:** (please circle all that apply)

- Appendix Removed
- Bladder Removed
- Mastectomy (Right, Left, Bilateral)
- Lumpectomy (Right, Left, Bilateral)
- Breast Biopsy (Right, Left, Bilateral)
- Breast Reduction
- Breast Implants
- Colectomy: Colon Cancer Resection
- Colectomy: Diverticulitis
- Colectomy: IBD
- Gallbladder Removed
- Coronary Artery Bypass
- PTCA
- Mechanical Valve Replacement
- Biological Valve Replacement
- Heart Transplant
- Joint Replacement, Knee (Right, Left, Bilateral)
- Joint Replacement, Hip (Right, Left, Bilateral)
- Joint Replacement within last 2 years
- Kidney Biopsy
- Kidney Removed (Right, Left)
- Kidney Stone Removal
- Kidney Transplant
- Ovaries Removed: Endometriosis
- Ovaries Removed: Cyst
- Ovaries Removed: Ovarian Cancer
- Prostate Removed: Prostate Cancer
- Prostate Biopsy
- TURP
- Skin Biopsy
- Basal Cell Cancer Surgery
- Squamous Cell Carcinoma Surgery
- Melanoma Surgery
- Spleen Removed
- Testicles Removed (Right, Left, Bilateral)
- Hysterectomy: Fibroids
- Hysterectomy: Uterine Cancer
- None

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**Skin Disease History:** (please circle all that apply)

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer
- None

Other \_\_\_\_\_  
\_\_\_\_\_

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 relative(s)?  
\_\_\_\_\_  
\_\_\_\_\_

**Please tell us what Pharmacy you use**

Pharmacy Name \_\_\_\_\_

Location \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

**Medications:** (Please enter all current medications)

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\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** (Please enter all allergies)  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History:** (Please circle all that apply)

- Currently Smokes - daily
- Currently Smokes - not daily
- Has smoked in the past
- Has never smoked
- Drug Use
- None

Other \_\_\_\_\_  
\_\_\_\_\_