SOLANO DERMATOLOGY
ASSOCIATES

Account #:_____ Today's Date:___/____/____

Patient Name:_____ Date of Birth: _____

1. **Preferred Pharmacy** Please help us identify the correct pharmacy location.

Primary Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City & State or Zipcode:_____

Secondary Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City & State or Zipcode:_____

2. **Tobacco Use** Have you ever used tobacco? ❑ No/never ❑ Yes

Smoking Tobacco Type	Use daily:	Usage per day	Age Started	Age Stopped	Non-Smoking Tobacco Type	Use daily:	Usage per day	Age Started	Age Stopped
Cigarette	❑	Packs Cigarettes			Chewing	❑			
Cigarillo	❑				Smokeless / E-Cigarettes	❑			
Cigar	❑				Snuff	❑			
Pipe	❑								

3. **Current Medications** Please list all medications, vitamins, & supplements you take including aspirin.

Medication Name	Dose (ex: mg)	How Often (ex: # / day)	Reason for Medication

❑ Patient does not currently take any medications ❑ List continues on back

Do you take antibiotics prior to dental work? ❑ Yes ❑ No

Do you get a yeast infection when you take antibiotics? ❑ Yes ❑ No

4. **Medication & Food Allergies** Please list any allergies or adverse reactions you have experienced.

Medication/Substance Name	Reaction

❑ Patient has no known allergies ❑ List continues on back

SOLANO DERMATOLOGY ASSOCIATES

Account#:_____ Today's Date:__/___/____

5. **Review of Systems**

Please check any skin symptoms you have experienced recently.

- ❑ Bleeding
- ❑ Blistering
- ❑ Blushing
- ❑ Bruising
- ❑ Burning
- ❑ Change in mole(s)
  - ❑ Color
  - ❑ Shape/Size
- ❑ Cold intolerance
- ❑ Cold sores
- ❑ Crusting
- ❑ Dry lips
- ❑ Dry skin
- ❑ Excessive sweating
- ❑ Eye irritation
- ❑ Hair
  - ❑ Brittle
  - ❑ Increased
  - ❑ Loss
  - ❑ Thinning
- ❑ Heat intolerance
- ❑ Hives
- ❑ Inflamed hair follicles
- ❑ Itching
  - ❑ Skin ❑ Scalp
- ❑ Large red bumpy nose
- ❑ Lesion(s)
  - ❑ Bleeding
  - ❑ Discharge
  - ❑ New
  - ❑ Oral
  - ❑ Painful
  - ❑ Recurrent bleeding
  - ❑ Spreading
- ❑ Nail
  - ❑ Changes
  - ❑ Pitting
  - ❑ Thickening
  - ❑ Separating
- ❑ Peeling feet
- ❑ Photosensitivity
- ❑ Rash
  - ❑ Painful
- ❑ Redness
- ❑ Scaling
- ❑ Scalp
  - ❑ Dry
  - ❑ Abscess
  - ❑ Tenderness
- ❑ Scarring
- ❑ Sensitive skin
- ❑ Skin cracking
- ❑ Skin irritation
- ❑ Skin nodules
- ❑ Skin Pigment
  - ❑ Color change
  - ❑ Darkening
  - ❑ Loss of color
- ❑ Skin sores
  - ❑ Non-healing
- ❑ Stinging
- ❑ Swelling
- ❑ Ulceration
- ❑ Varicose veins

6. **Past Medical History** Please check any medical conditions you have had.

Onset Date

- ❑ Asthma
- ❑ COPD
- ❑ Blood clots
- ❑ Congestive heart failure
- ❑ Coronary artery disease
- ❑ Diabetes
- ❑ Depression
- ❑ Gastrointestinal disease:
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Heart valve:
- ❑ Hepatitis/Liver disease

Type: A B C D E

Other:

Onset Date

- ❑ Heart murmur
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heartbeat
- ❑ Multiple sclerosis
- ❑ Renal (Kidney) disease
- ❑ Seizure disorder
- ❑ Spider/varicose veins
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ Pregnancy

Due Date:

- ❑ Other Conditions:

Onset Date

- ❑ Actinic keratosis
- ❑ Eczema
- ❑ Post-surgical keloids
- ❑ Psoriasis
- ❑ Psoriatic arthritis
- ❑ Rosacea
- ❑ Basal Cell Carcinoma
- ❑ Melanoma
- ❑ Squamous Cell Cancer
- ❑ Skin Cancer:
- ❑ Other Skin Conditions

7. **Past Surgical History** Please check any surgeries you have had.

Date

- ❑ Angioplasty
- ❑ Coronary Bypass
- ❑ Pacemaker
- ❑ Hip replacement

Date

- ❑ Knee replacement
- ❑ Organ transplant
- ❑ Thyroid surgery
- ❑ Tonsil removal

Date

- ❑ Skin Cancer Surgeries:
- ❑ Other Surgeries:

8. **Family History** Please check any conditions a genetic parent, full sibling, or child has had.

Relationship Onset Age

- ❑ Abnormal moles
- ❑ Acne (Nodulocystic)
- ❑ Allergies
- ❑ Dermatitis
- ❑ Keloids
- ❑ Psoriasis
- ❑ Psoriatic arthritis

Relationship Onset Age

- ❑ Rosacea
- ❑ Other Skin Conditions
- ❑ Melanoma
- ❑ Squamous cell carcinoma
- ❑ Basal cell carcinoma
- ❑ Skin cancer:

❑ No family history known (Adoption) ❑ No parent, full sibling, or child has had any of the above conditions.

Patient/Responsible Party Signature: _____ Date: _____