K·B
BEER DERMATOLOGY
COSMETIC, GENERAL & SURGICAL DERMATOLOGY

NAME:_____ DATE:_____

List all current medications (vitamins and OTC): _____

_____

_____

Pharmacy name and phone number: _____

PCP:_____

Medical History (Circle the following medical conditions that apply to you):

Anxiety	End Stage Renal Disease	Pacemaker/Defibrilator	Eczema
Arthritis	GERD (Reflux Disease)	Prostate Cancer	Psoriasis
Asthma	Hearing Loss	Radiation Treatments	Lupus
Atrial Fibrillation	Hepatitis	Seizures	Basal Cell Skin Cancer
Bone Marrow Transplant	High Blood Pressure	Stroke/TIA	Squamous Cell Skin Cancer
Benign Prostatic Hyperplasia	High Cholesterol	Blistering Sun Burns	Melanoma
Breast Cancer	HIV/AIDS	Bleeding Tendency	Aktinic Keratoses
Colon Cancer	Hyperthyroidism	Heart Attack	Acne
Pulmonary Disease/ COPD	Hypothyroidism	Stomach Ulcers	Keloids
Coronary Artery Disease/ Heart Disease	Leukemia	Hay Fever	Herpes Virus/ Cold Sores
Depression	Lung Cancer	Cataracts	Other (List below)
Diabetes	Lymphoma	Glaucoma	

Do you have a family history of skin cancer? Yes No If yes please list:_____

Please list all surgeries you have had in the past 5 years: _____

_____

_____

Please list any allergies you have: _____

_____

Do you have a living will? Yes No

Have you had the flu shot? Yes No Have you had the pneumonia shot? Yes No