

Home/cell Number: _____ Work Number: _____
(optional) Email address: _____

Referral Information:

How did you hear about the Cosmetic Dermatology and Laser Center?

Please circle the appropriate response(s):

Internet Friend/Family Physician UMHS Dermatology Clinic

Other (please specify): _____

If you were sent to us by a physician, please give us as much information as possible below:

Referring Physician Information:

Name: _____

Specialty (dermatology, primary care, etc.): _____

Address: _____

Medications (please list any medications you are taking including vitamins and supplements):

Allergies to medications:

Latex allergy? Yes No Unsure

_____ Sensitivity to local anesthesia

If yes, please circle all that apply: Lidocaine Epinephrine

Reason(s) you are here: _____

Past Dermatologic History:

_____ Previous laser or cosmetic surgery

If yes, please specify: _____

_____ Skin cancer

If yes, specify type if known: _____

_____ Abnormal (hypertrophic or keloidal) scarring

_____ Cold sores

_____ Accutane (isotretinoin) use.

If yes, when did you last take Accutane (isotretinoin)?: _____

_____ Soriatane (acitretin) use

Past Medical History:

_____ Heart disease

If yes, please circle all that apply: chest pain pacemaker defibrillator

heart valve disease heart attack irregular heart beat (arrhythmia)

require antibiotics before procedures artificial heart valve

_____ Seizures

_____ Eye disease

_____ HIV/AIDS

_____ Hepatitis

_____ Neurologic disease (such as myasthenia gravis)

_____ Autoimmune disease (such as lupus or scleroderma)

_____ Diabetes

_____ Lung disease

_____ Need for supplemental oxygen

_____ Kidney disease

_____ Frequent or easy bleeding

_____ Psychiatric/mental disorder

If yes, please circle all that apply: depression anxiety psychiatric hospitalization

other: _____

Social History:

How many alcoholic beverages do you drink per week? _____

Do you smoke? Yes No

Are you pregnant? Yes No

Family History:

Do you have a family history of melanoma? Yes No

If yes, relationship to you: _____

Do you have a family history of bleeding disorders? Yes No

Review of Systems:

Are you experiencing any of the following at this time?

_____ Headaches

_____ Visual Problems

_____ Unexplained

_____ Nausea

_____ Joint pain

weight loss

_____ Vomiting

_____ Circulation

_____ Varicose Veins

_____ Fever

_____ Problems

_____ Mouth Sores

_____ Chills

_____ Muscle aches

_____ depression/ mood

_____ Diarrhea

_____ Seizures

changes

_____ Constipation

_____ Bleeding

Please list any major current or past medical problems not noted above:
