Fort Worth Dermatology Associates, P.A.
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Patient Name: _____ Date: _____

Date of Birth: _____ Reason for Visit: _____

Please indicate any medical conditions that you currently have:

- ◯ Anxiety
- ◯ Arthritis
- ◯ High Blood Pressure
- ◯ Heart Disease
- ◯ Stroke
- ◯ Diabetes
- ◯ Kidney/Bladder Disease or Incontinence
- (circle all that apply)
- ◯ Liver disease/hepatitis
- ◯ HIV/AIDS
- ◯ Lung Disease
- ◯ Cancer: type _____
- _____
- ◯ Leukemia/Lymphoma
- ◯ Neurologic/Balance Issues
- # of falls in the past 12 months
- _____
- ◯ Other _____
- _____
- _____

Past Surgeries:

Skin Cancer:

- ◯ Basal Cell Carcinoma
- ◯ Squamous Cell Carcinoma
- ◯ Melanoma
- ◯ Other cancer (type): _____
- ◯ Organ Transplant (type): _____
- ◯ Joint Replacement (type): _____
- ◯ Heart
- Pacemaker/Defibrillator
- Coronary Artery Bypass
- Stent Placement
- Valve Replacement
- ◯ Other: _____
- _____

Medications: Please list all medications you are currently taking including over the counter meds. You may also attach and give a list to the medical assistant.

_____ _____
_____ _____
_____ _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Drug Allergies: Please list any allergies you have had to medications along with the type of reactions that you experienced _____
_____
_____

Have you had an inpatient stay in any hospital within the last 30 days? ____ Y ____ N

Do you have an advanced directive or medical power of attorney? ____ Y ____ N
If so, who is named in these documents as your caregiver should you need to be cared for?
_____

Height _____ Weight _____

Have you had a flu vaccine this year? _____ Y _____ N
Date of vaccine? _____

Have you ever had a pneumonia vaccine? ____ Y ____ N
If so, when? _____

Have you had a COVD vaccine? ____ Y ____ N
If so, when and what type? _____

How much alcohol do you drink per day? _____

Do you currently smoke? _____ Y _____ N
If so, how much per day: _____

Do you feel safe at home _____ Y _____ N

Do you experience food insecurity, housing instability, transportation needs or utility difficulties
_____ Y _____ N

Do you have a family history of skin cancer? _____ Y _____ N
If known, what type and which family member _____

_____ _____
Patient Signature Date