Fort Worth Dermatology Associates, P.A.

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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 disease
- ☐ Liver disease/hepatitis
- ☐ HIV/AIDS
- ☐ Lung disease
- ☐ Cancer: type ______________
- ☐ Leukemia/lymphoma
- ☐ 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.

______________ ______________
______________ ______________
______________ ______________
______________ ______________
______________ ______________
______________ ______________

Drug Allergies: Please list any allergies you have had to medications along with the type of reactions you may have had.

____
____
____

Name: ______________________________ Date of Birth: ______________

Have you had an inpatient stay in any hospital within the last 30 days?
____ Yes ____ No

Do you have an advanced directive or medical power of attorney? ____ Yes ____ No
If so, who is named in these documents as your caregiver should you need to be cared for? ______________________________

Height ____________ Weight ____________

Have you had flu vaccine this year? ____ Yes ____ No
Date of vaccine? ______________________________

Have you ever had a pneumonia vaccine? ____ Yes ____ No
If so, when? ______________________________

Have you had a COVID vaccine? ____ Yes ____ No
If so, when and what type? ______________________________

How much alcohol do you drink per day? ______________________________

Do you currently smoke? ____ Yes ____ No
If so, how much per day? ______________________________

Do you have a family history of skin cancer? ____ Yes ____ No
If known, what type and which family member?
____

____
Patient signature

____
Date