MYSTIC VALLEY
dermatology
ASSOCIATES, P.C.

Date: _____ Name: _____ DOB: _____

Phone Number: _____ Primary Care Physician: _____

What is the main reason for your visit today? : _____

Who recommended this visit? _____

Do you have allergies to medications? ☐ Yes ☐ No
If yes please list drug & reaction: _____

Do you have allergies to latex? ☐ Yes ☐ No

Allergies to other items? (food, pollen, etc.) ☐ Yes ☐ No
If yes please list: _____

Medications: Please list any medications you are currently taking. Include birth control pills, over the counter medications, and herbs:

Are you pregnant? ☐ Yes ☐ No ☐ Not applicable

General Medical History
Please list any medical conditions. Include all conditions with which you have ever been diagnosed, or for which you take medication, even if they are under good control.

			If yes please specify:
Cardiac	☐ Yes	☐ No	
Cardiac valve replacement	☐ Yes	☐ No	
Respiratory	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Poor healing	☐ Yes	☐ No	
Keloids/abnormal scars	☐ Yes	☐ No	
Cancer (other than skin)	☐ Yes	☐ No	
Glaucoma/Cataracts	☐ Yes	☐ No	
High blood pressure	☐ Yes	☐ No	
High cholesterol	☐ Yes	☐ No	
Neurologic/Stroke	☐ Yes	☐ No	
Kidney problems	☐ Yes	☐ No	
Bleeding disorder	☐ Yes	☐ No	
Psychiatric (anxiety, depression, etc.)	☐ Yes	☐ No	

Other/Explain further: _____

Surgical History (please list type and year):

Do you have any metal in your body from orthopedic or other surgeries? ☐ Yes ☐ No
If yes, list location/date: _____

Do you pre-medicate before a surgical procedure due to an <u>artificial heart valve</u>? ☐ Yes ☐ No
If yes, please list what you pre-medicate with: _____

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No
If yes, please specify: _____

Have you been diagnosed with Infectious Disease? (HIV, Hepatitis, MRSA, Tuberculosis) ☐ Yes ☐ No
If yes please specify: _____

Have you ever smoked tobacco? ☐ Never ☐ in the Past ☐ Currently

Do you consume alcohol? ☐ No ☐ 1-2/week ☐ 3-4/week ☐ 5+/week

Occupation: _____

Have you ever been diagnosed with:
Melanoma? ☐ Yes ☐ No
Basal, Squamous Cell or other skin cancer(s)? ☐ Yes ☐ No
Any other skin condition? ☐ Yes ☐ No
If other, please specify: _____

How many times in your life have you had a sunburn bad enough to make you blister?
☐ Never ☐ 1 time ☐ 2 or more times

Have you ever used tanning beds?
☐ Never ☐ in the Past ☐ Currently

Has anyone in your immediate family had skin cancer? (parents, siblings, children)
☐ Yes ☐ No ☐ Unknown

If yes, what kind?
☐ Basal or Squamous cell (most common)
☐ Melanoma (less common, but more serious)
☐ Other: _____

Pharmacy Name: _____
Pharmacy Phone: _____
Pharmacy Address: _____

Height: _____ **Weight:** _____

92 Montvale Avenue, Suite 3000, Stoneham, MA 02180
Phone: (781) 438-6350 | Fax: (781) 279-0430 | Web: www.mvderm.com
Medford | Salem, NH | Stoneham | Wilmington | Winchester