

Levy Dermatology, P.C.

www.levydermatology.com

1920 Kirby Parkway
Suite 204
Germantown, TN 38138
Ph 901.624.3333
Fax 901.624.1203

PATIENT NAME: _____ **TODAY'S DATE** ____/____/____

LAST NAME

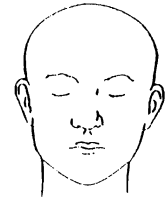
FIRST NAME

M / F Age: _____ Date of Birth: ____/____/____

Married Single Domestic Partner Separated Widowed Divorced

Preferred Pharmacy (phone number if known) _____

REASON FOR VISIT: (Mark on the diagram the location of your skin condition)



How long? _____ Past treatments, if any? _____

LIST ALL CURRENT MEDICATIONS:

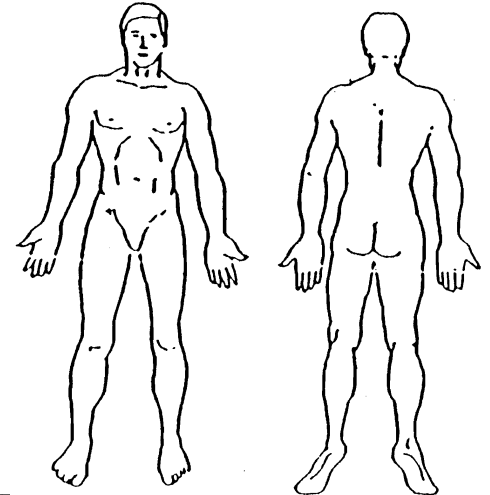
(Include prescriptions and over-the-counter):

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Have you ever had a reaction or allergy to any medication? YES NO

If yes, list below and describe reaction:

Have you ever had a reaction to local anesthesia? YES NO If yes, explain:



SKIN: Have you ever had? Actinic Keratoses Basal Cell Carcinoma Squamous Cell Carcinoma

Melanoma Other skin cancer _____

If yes, please provide details _____

Family history of skin cancer? YES NO If yes, please explain _____

Do you have a history of any other skin diseases? YES NO If yes, please explain _____

Have you had atypical or unusual moles? YES NO If yes, any removed? YES NO _____

Do you develop keloid scars in response to surgery? YES NO

Do you develop skin rashes in reaction to? Bandages Neosporin Polysporin Other _____

Are you allergic to latex? YES NO Do you require antibiotics before dental procedures? YES NO

List any other diseases or conditions we should be aware of: _____

PREVIOUS SURGERY? If yes, explain type of surgery and give dates: _____

REVIEW OF SYSTEMS: Have you had any problems with the following body systems? If so, explain:

System	YES	NO	Explain
Eyes			
Ears/Nose/Mouth/Throat			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Neurologic			
Psychiatric			
Endocrine			
Lymphatic			
Allergies			

Do you have now or have you ever had diseases / conditions of:

Lungs:	YES	NO		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		
Sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>		
Cardiovascular:				
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>		
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>		
Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>		
Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>		
Neurological Disease:				
Epilepsy / Seizures	<input type="checkbox"/>	<input type="checkbox"/>		
Fainting with procedures	<input type="checkbox"/>	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		
GYN (Women Only):				
Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>		
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>		
Due date _____	<input type="checkbox"/>	<input type="checkbox"/>		
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you trying to get pregnant?	<input type="checkbox"/>	<input type="checkbox"/>		
Other Systemic:	YES	NO		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>		
Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>		
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer, type _____	<input type="checkbox"/>	<input type="checkbox"/>		
Organ Transplant _____	<input type="checkbox"/>	<input type="checkbox"/>		
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>		
Autoimmune Disease:				
Lupus	<input type="checkbox"/>	<input type="checkbox"/>		
Connective Tissue Disease	<input type="checkbox"/>	<input type="checkbox"/>		
Gastrointestinal:				
Hepatitis B or C (please circle)	<input type="checkbox"/>	<input type="checkbox"/>		
Yeast infection with antibiotics	<input type="checkbox"/>	<input type="checkbox"/>		
Joint Disease:				
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		
Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>		
Mental Health:				
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>		
Depression	<input type="checkbox"/>	<input type="checkbox"/>		

SOCIAL HISTORY:

Do you drink alcohol? YES NO # of _____ drinks per week
 Do you smoke? YES NO how much? _____
 Have you smoked in the past? YES NO when did you stop? _____
 Do you use recreational drugs? YES NO which? _____ how often? _____

Completed by: Patient _____ Signed by Patient _____ Date _____

Parent/Guardian _____ Your Name _____ Date _____