Downtown Dermatology

291 Broadway, Suite 1803 New York, NY 10007 Ph. (212) 233-2995 Fax. (212) 227-6577

Patient Name: _____

Date: ____/_____/____ **Last Total Skin Exam:** ____/_____/_____

Reason for Consultation: _____

Duration: _____ **Days** _____ **Wks** _____ **Mths** _____ **Yrs** **Location:** _____

CHECK ALL THAT APPLY:

☐ Persistent ☐ Episodic ☐ Recurrent ☐ Bleeding ☐ Scabbing/Crusting
☐ Burning ☐ Itching ☐ Flaking ☐ Redness ☐ Blisters ☐ Spreading
☐ New Lesions ☐ Roughness ☐ Painful ☐ Change in Color/Shape

CHECK ALL THAT APPLY:

MEDICATIONS	SOCIAL HISTORY	FAMILY HISTORY	ALLERGIES
☐ NONE	☐ MARRIED	☐ NONE	☐ NONE
	☐ WIDOWED	☐ MELANOMA	☐ ASPIRIN
	☐ DIVORCED	☐ DYSPLASTIC NEVI	☐ PENICILLIN
	☐ SINGLE	☐ BASAL CELL	☐ LATEX
	☐ PARTNERED		☐ OTHER
	WEIGHT: ___(LBS HEIGHT:_____	PACEMAKER: Y ◯ N ◯ PRE MEDICATION: Y ◯ N ◯	

MEDICAL HISTORY		SURGERIES
☐ NONE	☐ ASTHMA	☐ NONE
☐ CANCER	☐ CHOLESTEROL	
☐ BLOOD TRANSFUSION	☐ THYROID DISEASE	**TANNING BED USE**: Y ◯ N ◯
☐ COLLAGEN VASUCLAR DISEASE	☐ CARDIAC DISEASE	**SMOKING**: CIG ◯ CIGAR ◯ NO ◯
☐ BLEEDING DIATHESES	☐ HEPATITIS A ◯ B ◯ C ◯	**ALCOHOL**: SOCIALLY ◯ DAILY ◯ NO ◯
☐ DIABETES	☐ HIGH BLOOD PRESSURE	

PAST COSMETIC PROCEDURES: ☐ LASER ☐ BOTOX ☐ FILLERS PEELS ☐ FACE LIFT ☐ TATTOO

IF FEMALE: MENSES: REGULAR ◯ IRREGULAR ◯ **LAST MENTRUAL PERIOD:** _____ **PREGNANT**: Y ◯ N ◯
BREASTFEEDING: Y ◯ N ◯