

Name: _____ Referring Physician: _____

How did you hear about ASCS? Newspaper Magazine Website Other: _____

Age: _____ Birthdate: _____ Sex: M F Race: _____ Occupation: _____

Summarize your skin problems: _____

How long have you had your skin problem? _____

On what part of your body did the problem first start? _____

What other parts of your body are involved? _____

Is your skin problem caused or aggravated by your job? Y N

What treatments have you had for your skin problems? (Include over-the-counter and prescribed therapy) Please be specific: _____

Do you have any of the following symptoms?

- | | | |
|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N No Symptoms | <input type="checkbox"/> Y <input type="checkbox"/> N Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Chronic Cough |
| <input type="checkbox"/> Y <input type="checkbox"/> N Itching | <input type="checkbox"/> Y <input type="checkbox"/> N Fatigue | <input type="checkbox"/> Y <input type="checkbox"/> N Swollen Lymph Nodes |
| <input type="checkbox"/> Y <input type="checkbox"/> N Burning | <input type="checkbox"/> Y <input type="checkbox"/> N Unintentional Weight Loss | <input type="checkbox"/> Y <input type="checkbox"/> N Easy Bruising |
| <input type="checkbox"/> Y <input type="checkbox"/> N Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Nausea / Vomiting | <input type="checkbox"/> Y <input type="checkbox"/> N Anxiety |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Abdominal Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches |
| <input type="checkbox"/> Y <input type="checkbox"/> N Drainage | <input type="checkbox"/> Y <input type="checkbox"/> N Diarrhea | <input type="checkbox"/> Y <input type="checkbox"/> N Eye Irritation |
| <input type="checkbox"/> Y <input type="checkbox"/> N Photosensitivity | <input type="checkbox"/> Y <input type="checkbox"/> N Constipation | <input type="checkbox"/> Y <input type="checkbox"/> N Joint pains |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chills | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath | |

Do you have a history of skin cancer? Y N Types: _____

Do you have a family history of melanoma or other skin cancer? Y N Details: _____

Please list all medications you take (include over-the-counter and prescribed medicines):

MEDICATION	REASON TAKEN	DATE STARTED	DATE STOPPED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all known allergies (including medication): _____

Smoke? Y N Alcohol consumption: Occasionally Daily None

FOR WOMEN ONLY

Are you pregnant? Y N If yes, expected date of delivery? _____ Are you breastfeeding? Y N

Are you on Birth Control? Y N If yes, type/name: _____ Do you have regular menstrual cycles? Y N

PAST MEDICAL HISTORY

Do you have a history of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valves |
| <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Lupus | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N HIV | <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding Disorders | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritic Joints |
| <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker / Defibrillator | <input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hayfever | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Environmental Allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease | |

Other Medical Conditions: _____



Signature: _____ Date: _____

Date Reviewed: _____ Initials: _____ Date Reviewed: _____ Initials: _____