Providence Medical Group/Sunset Dermatology
417 SW 117th Ave., Ste 100
Portland, OR 97225

Dermatology Patient History Form

Name: _____ Today's Date: _____

Date of Birth: _____

Primary Care Physician: _____ Referring Provider: _____

Primary Skin Concern: _____

- Location: _____
- How long have you had this problem? _____
- What have you used to treat it? _____

Other Skin Concerns: _____

_____

_____

_____

Current Symptoms:

□Fever/Chills	□Kidney Problems	□Cough	□Stomach/Bowel problems
□Eye Problems	□Arthritis	□Shortness of breath	□Seizures
□Chest Pain	□Depression/Anxiety	□Leg Swelling	□Other □**NONE**

Other Symptoms: _____

Personal Medical Problems:

Melanoma	□Yes	□No	Comments _____
Basal/Squamous cell carcinoma	□Yes	□No	Comments _____
Eczema	□Yes	□No	Comments _____
Asthma	□Yes	□No	Comments _____
Hay fever/allergies	□Yes	□No	Comments _____
Excessive bruising or bleeding	□Yes	□No	Comments _____
Keloids/scarring	□Yes	□No	Comments _____
Allergic to latex or rubber	□Yes	□No	Comments _____
Allergic to tape/bandages	□Yes	□No	Comments _____
Diabetes	□Yes	□No	Comments _____
Heart disease	□Yes	□No	Comments _____
Hepatitis or liver disease	□Yes	□No	Comments _____
HIV disease	□Yes	□No	Comments _____
Immunosuppression/Organ transplant	□Yes	□No	Comments _____
Gastrointestinal disease	□Yes	□No	Comments _____
Kidney disease	□Yes	□No	Comments _____
Cancer	□Yes	□No	Comments _____

Other Medical Problems: _____

Family Medical History:

Prior Surgeries:

SEE REVERSE

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Family Hx of melanoma	☐Yes ☐No	Allergies: _____
Tanning Bed Use	☐Yes ☐No	
Pregnant	☐Yes ☐No	Medications: _____
Trying to get pregnant	☐Yes ☐No	_____
Breastfeeding	☐Yes ☐No	_____
Artificial Joints or heart valves	☐Yes ☐No	_____
Tobacco use	☐Yes ☐No	_____
Alcohol use	☐Yes ☐No	_____
Occupation: _____		Hobbies: _____