BDA BAKAL DERMATOLOGY ASSOCIATES

Patient Name: ____ **Date of Birth:** _________________

<u>Past Medical History:</u> (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial fibrillation	GERD	Prostate Cancer
Bone Marrow Transplantation	Hearing Loss	Radiation Treatment
Breast Cancer	Hepatitis	Seizures
Colon Cancer	High Blood pressure	Stroke
COPD	HIV/AIDS	Thyroid Problems
Coronary Artery Disease	High Cholesterol	

Other: ____

<u>Past Surgical History</u>: (please circle all that apply)

Appendix Removed	Joint Replacement, Hip (Right, Left, Bilateral)
Bladder Removed	Joint Replacement within last 2 years
Mastectomy (Right, Left, Bilateral)	Kidney Biopsy (Nephrectomy)
Lumpectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Breast Biopsy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Reduction	Kidney Transplant
Breast Implants	Ovaries Removed: Endometriosis
Colectomy: Colon Cancer Resection	Ovaries Removed: Cyst
Colectomy: Diverticulitis	Ovaries Removed: Ovarian Cancer
Colectomy: IBD	Prostate Removed: Prostate Cancer
Gallbladder Removed	Prostate Biopsy
Coronary Artery Bypass	TURP (Prostate Removal)
Mechanical Valve Replacement	Spleen Removed
Biological Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Heart Transplant	Hysterectomy: Fibroids
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer

Other: ____

<u>Skin Disease History</u>: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	

Other: ____

Do you wear Sunscreen? Yes No If yes, what SPF? ___________

Do you tan in a tanning salon? Yes No

<u>Medications</u>: (please list all prescriptions, over the counter medications, vitamin and herbal supplements)

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____

____

Allergies:

____

____

____

Social History: (please circle all that apply)

Cigarette Smoking:	Alcohol Use:
Currently Smokes	None
Has smoked in the past	Less than 1 drink per day
Never smoked	1-2 drinks per day
Former Smoker	3 or more drinks per day

Family History: (please circle all that apply)

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? ____

Do you have a family history of Basal Cell Carcinoma or Squamous Cell Carcinoma? Yes No

If yes, which relative(s)? ____

Review of Systems: (please circle all that apply)

Allergy to adhesive	Chest pain
Allergy to Lidocaine	Fever or Chills
Allergy to topical antibiotic	Night Sweats
Artificial heart valve	Unintentional weight loss
Artificial joints within the past two years	Thyroid problems
Blood thinners	Sore throat
Defibrillator	Bloody Stool
MRSA	Bloody urine
Pacemaker	Joint aches
Premedication prior to procedures	Muscle weakness
Rapid heartbeat with Epinephrine	Neck stiffness
Pregnancy or planning pregnancy	Headaches
Problems with bleeding	Seizures
Problems with healing	Cough
Problems with healing (hypertrophic/keloids)	Shortness of breath
Rash	Wheezing
Immunosuppression	Anxiety
Hayfever	Depression

Basic Health Services:

We are board-certified experts in the treatment of skin, hair and nails. We also offer many cosmetic services to rejuvenate the skin and improve your overall appearance. Some of the services we offer include mole removals, microdermabrasion, Botox therapy, deep wrinkle fillers, leg vein treatments, laser surgery, in addition to general medical and surgical skin care. Please let us know if you are interested in any of the following services:

- ☐ **I would like a full skin examination to check for any abnormal moles or growths. (The nurses will ask you to change into a gown once in the examination room)**
- ☐ **I would be interested in skin care products that will protect my skin from sun damage and reduce the signs of current damage.**
- ☐ **I am interested in the long term removal of unwanted hair.**
- ☐ **I am interested in removal of liver spots or enlarged blood vessels on my face.**
- ☐ **I would like to learn more about treating leg veins.**
- ☐ **I have “crow’s feet” around my eyes or deep lines on my forehead and/or cheeks that I would like to treat.**