KLEIN DERMATOLOGY & ASSOCIATES

PATIENT NAME:_____ I PREFER TO BE CALLED: _____

OCCUPATION: _____ CITY/STATE BORN IN: _____

PLEASE CIRCLE YOUR LIFETIME EXPOSURE TO THE SUN: HIGH MODERATE LOW

PLEASE CIRCLE "YES" OR "NO" TO THE FOLLOWING QUESTIONS. **DO YOU:**
USE A TANNING BED? **Y N** USE SUNSCREEN? **Y N** HAVE A HISTORY OF BLISTERING SUNBURNS? **Y N**

DO YOU HAVE OR HAVE YOU EVER HAD:

HIGH BLOOD PRESSURE	**Y**	**N**	HEPATITIS	**Y**	**N**
ULCER	**Y**	**N**	BLOOD TRANSFUSION	**Y**	**N**
HEART ATTACK/ANGINA	**Y**	**N**	ARTIFICIAL HEART VALVE OR JOINT	**Y**	**N**
IRREGULAR HEART BEAT	**Y**	**N**	ABNORMAL HEALING OR SCARRING	**Y**	**N**
SEIZURE DISORDER	**Y**	**N**	SURGERY	**Y**	**N**

EXPLAIN: _____

DO YOU OR ANY OF YOUR BLOOD RELATIVES HAVE A HISTORY OF THE FOLLOWING, IF SO PLEASE CIRCLE:

DIABETES	ME	RELATIVE	MELANOMA	ME	RELATIVE
HAYFEVER	ME	RELATIVE	OTHER SKIN CANCER	ME	RELATIVE
ECZEMA	ME	RELATIVE	PSORIASIS	ME	RELATIVE
ASTHMA	ME	RELATIVE	BLEEDING DISORDER	ME	RELATIVE

EXPLAIN: _____

DO YOU HAVE ANY CURRENT HEALTH PROBLEMS NOT ADDRESSED ABOVE? IF SO, PLEASE CIRCLE:

BLOOD/CIRCULATORY SYSTEM	KIDNEYS	ANXIETY/DEPRESSION
NERVOUS SYSTEM	LIVER	LUNGS
PERSISTENT HEADACHES	DIGESTIVE SYSTEM	THYROID GLAND

EXPLAIN: _____

PLEASE LIST ALL CURRENT MEDICATIONS (including over the counter, vitamins, herbs, supplements):

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS, TOPICAL PRODUCTS OR ADHESIVES? IF SO, PLEASE LIST:

_____

Today's Date: _____ Your Initials: _____

Thank you for your assistance!