Integrated Dermatology Clinic
281-829-8288

Integrated Plastic Surgery
281-404-5454

PATIENT NAME: _____ **DOB:**_____ **DATE:**_____

PLEASE TELL US THE REASON FOR YOUR VISIT:

_____

_____

PAST MEDICAL HISTORY (please circle all that apply)

Anxiety	Hearing loss
Arthritis	Hepatitis
Asthma	High blood pressure
Atrial fibrillation	HIV/AIDS
Bone marrow transplant	High cholesterol
BPH (enlarged prostate)	Hyperthyroid
Breast cancer	Hypothyroid
Colon cancer	Leukemia
Chronic obstructive pulmonary disease (COPD)	Lung cancer
Coronary artery disease	Lymphoma
Depression	Prostate cancer
Diabetes	Radiation treatment
End stage renal disease	Seizures
GERD (reflux)	Stroke
Other:	

PAST SKIN HISTORY (circle all that apply)

Actinic keratoses	Hay fever/seasonal allergies
Asthma	
Blistering sunburns	

Skin cancer (if yes, please give us the location (for example: nose) and year

-Basal cell cancer

_____

-Squamous cell cancer

_____

-Melanoma

_____

-Precancerous moles

Do you wear sunscreen?	Do you have a famiy history of melanoma?
__Yes __No	__Yes __No
Do you tan in a tanning salon?	If yes, which relative(s)?
__Yes __No	

MEDICATIONS (please list or attach)

_____

_____

_____

_____

_____

ALLERGIES (please list or attach)

_____

_____

5061 FM 2920
Spring, Tx 77388

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PATIENT NAME: _____ **DOB:**_____ **DATE:**_____

SMOKING HISTORY

Do you smoke? __Yes __Quit __Never
-If Yes, how many packs per day do you smoke?_____

REVIEW OF SYSTEMS	ALERTS
Circle any that you are currently experiencing	**Circle any that apply**
Problems with bleeding	Allergy to adhesive
Problems with healing	Allergy to lidocaine
Problems with scarring (keloids/thick scars)	Allergy to topical antibiotic ointments (eg neosporin)
Rash	Artificial heart valve
Immunosuppression	Artificial joints within past 2 years
Hay fever	Blood thinners
Chest Pain	Defibrillator
Fevers or chills	MRSA
Night sweats	Pacemaker
Unintentional weight loss	Premedication prior to procedures
Thyroid problems	Rapid heart beat with epinephrin
Sore throat	Pregnancy or planning a pregnancy
Blurry vision	
Abdominal pain	
Bloody stool	
Bloody urine	
Joint aches	
Muscle weakness	
Neck stiffness	
Headaches	
Seizures	
Cough	
Shortness of breath	
Wheezing	
Anxiety	
Depression	

PHARMACY INFORMATION

We will e-prescribe your medications. Please tell us your preferred pharmacy.
Pharmacy name:_____
Pharmacy address:_____Zip:_____Tel:_____

COMMUNICATION PREFERENCES

If your preferred language is NOT English, please specify your preferred language:_____
What is your race? Decline to answer / White / American Indian / Asian / Black / Native Hawaiian / Other
What is your ethnicity? Decline to specify / Hispanic or Latino / Not hispanic or Latino / Other
Please circle your preferred method of communication during office hours (8am-5pm).
Patient Portal:_____
Text (please provide preferred number):_____
Phone (please provide preferred number)_____
Is it okay to leave a detailed message (for example, a message with test results?)
___Yes ___No
Who is you referring physician or primary care provider (first and last name)?_____
Tel:_____Fax:_____

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