Biltmore Dermatology Associates
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Patient History Form

Patient Name: MR#

Primary Care Physician: _____

Allergies to medications: ☐ None 1. _____ Reaction _____
2. _____ Reaction _____

List Medical Problems:

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

List Surgeries: (Including cosmetic procedures)

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Have you ever had a skin biopsy? If so, for what reason? _____

Current Medications: ☐ None 1. _____ 4. _____
(Include herbal, vitamin, over the counter and homeopathic remedies) 2. _____ 5. _____
3. _____ 6. _____

	YES	NO		YES	NO		YES	NO
Aspirin/Motrin/Advil	◯	◯	Birth Control Pills	◯	◯	Are you pregnant	◯	◯
Coumadin……	◯	◯	Are you breast feeding	◯	◯	Plan on becoming pregnant	◯	◯

Review of Systems Screen (Current or past problems with)

	YES	NO		YES	NO		YES	NO
Blood/Bleeding Disorder….	◯	◯	Arthritis……	◯	◯	Cancer (non-skin)……	◯	◯
Heart Disease……	◯	◯	Diabetes……	◯	◯	Skin Disease……	◯	◯
Kidney Disease……	◯	◯	High Blood Pressure……	◯	◯	Skin Cancer (Basal Cell or Squamous Cell)…..	◯	◯
Lung Disease……	◯	◯	Received Blood Transfusions….	◯	◯	Melanoma……	◯	◯
Thyroid Disease……	◯	◯	Psychological Disorders……	◯	◯	Pre Skin Cancer (Actinic Keratosis)……	◯	◯
Immunologic Disease……	◯	◯	Latex/rubber/nickel/food……	◯	◯	Endometriosis……	◯	◯
Liver Disease or Hepatitis…	◯	◯	Infectious Disease (TB, HIV)……	◯	◯			

Do you	YES	NO		YES	NO
Have a pacemaker or defibrillator……	◯	◯	Have an artificial joint or heart valve……	◯	◯
Take antibiotics prior to surgical procedures……	◯	◯	Form Keloids……	◯	◯

Family History (Check the following medical conditions which have occurred in your family)

Disease	Mother	Father	Blood Relative	None	Disease	Mother	Father	Blood Relative	None
Acne……	◯	◯	◯	◯	Hay Fever	◯	◯	◯	◯
Arthritis……	◯	◯	◯	◯	Hives	◯	◯	◯	◯
Asthma……	◯	◯	◯	◯	Lupus	◯	◯	◯	◯
Cancer……	◯	◯	◯	◯	Psoriasis	◯	◯	◯	◯
Diabetes……	◯	◯	◯	◯	Melanoma	◯	◯	◯	◯
Eczema……	◯	◯	◯	◯	Skin Cancer	◯	◯	◯	◯

Social History	YES	NO		YES	NO		YES	NO
Do you live alone?	◯	◯	Do you drink alcohol?	◯	◯	Do you smoke or use tobacco products?	◯	◯

Occupation _____ Hobbies/Leisure Activities_____

Patient's Signature_____ Date _____

Reviewed by: _____ Date _____