CLEARVIEW
DERMATOLOGY
The Clear Path to Healthy Skin

Health Evaluation Form

The following questionaire is a comprehensive look at your health. It will take about 5 minutes to complete.

Full Name *

First Name Last Name

Phone Number *

Area Code Phone Number

Gender *

- Male
- Female

Date of Birth

Month Day Year

Past Medical History (please circle all that apply) *

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrilation
- Bone Marrow Transplant
- BPH
- Breast Cancer
- Hearing Loss
- High Blood Pressure
- High Cholesterol
- Leukemia
- Lymphoma
- Radiation Treatment
- Stroke
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hepatitis
- HIV/AIDS
- Thyroid Problems
- Lung Cancer
- Prostate Cancer
- Seizures
- None of the above

Past Surgical History (please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy
- ☐ Lumpectomy
- ☐ Breast Biopsy
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy;Colon Cancer Resection
- ☐ Colectomy; Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee
- ☐ Joint Replacement, Hip
- ☐ Joint Replacement w/in last 2 years
- ☐ Kidney Biopsy (Nephrectomy)
- ☐ Kidney Removed
- ☐ Kidney Stones
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP (Prostate Removal
- ☐ Spleen Removed
- ☐ Testicles Removed
- ☐ Hysterectomy (Fibroids)
- ☐ Hysterectomy: Uterine Cancer
- ☐ _____

Skin Disease History (please check all that apply) *

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ None Of the Above
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Hay Fever/Allergies
- ☐ _____

Review of Systems Are you currently experiencing any of the following? (Please check any that apply) *

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring
- ☐ Immunosuppresion
- ☐ Unintentional weight loss
- ☐ Joint Aches
- ☐ Anxiety
- ☐ Depression
- ☐ None Of the Above
- ☐ _____

Family History (please check all that apply). *

- ☐ Diabetes
- ☐ Hypertension
- ☐ Skin Surgical Procedures
- ☐ Psoriasis
- ☐ Asthma
- ☐ None of the above
- ☐ _____

Alerts (Please check any that apply) *

- ☐ Allergy to adhesive
- ☐ Blood Thinners
- ☐ Allergy to lidocaine
- ☐ Defribrilator
- ☐ Allergy to topical antibiotics
- ☐ MRSA
- ☐ Artificial heart valve
- ☐ Pacemaker
- ☐ Requires antibiotics prior to procedure
- ☐ Rapid heart beat with epinephrine
- ☐ Pregnant/trying to conceive
- ☐ None of the above
- ☐ _____

Additional info you might want to share

Do wear Sunscreeen? *

- ○ Yes
- ○ No

Do you have a family history of Melanoma? *

- ◯ Yes
- ◯ No

Cigarette Smoking Status: *

- ◯ Currently Smokes
- ◯ Have smoked in the past
- ◯ Never Smoked
- ◯ _____

Medications: (Please list all current medications).

Allergies: (Please list all allergies).

Preferred Pharmacy (Name & Number) *