BROWN DERMATOLOGY
BROWN PHYSICIANS, INC.

PATIENT NAME: _____Date of Birth: _____

REASON FOR VISIT: _____

Email: _____

PERSONAL HISTORY

SKIN CANCER: ☐ NO ☐ YES

If yes what type? _____Location_____When_____

Type? _____Location_____When_____

History of skin biopsies and/or surgeries:

Where/What/When: _____

Where/What/When: _____

Where/What/When: _____

Has anyone in your family had: ☐ skin cancer ☐melanoma ☐psoriasis ☐asthma / hay fever / eczema?

MEDICATIONS

List all medications you are currently taking including aspirin, vitamins, and any over-the-counter medications:

_____

_____

ALLERGIES

Do you have any allergies? ☐ **NO** ☐ **YES**
If yes, please list them:

_____

_____

PRIMARY CARE PHYSICIAN

Name: _____ Address: _____Phone #: _____

PHARMACY

Name: _____ Address: _____Phone #: _____

Please flip over ----------→

BROWN DERMATOLOGY
BROWN PHYSICIANS, INC.

PATIENT NAME: _____

DOB: _____

REVIEW OF SYSTEMS:

Please circle if you are currently experiencing any of the following symptoms/conditions:

Eczema	Thyroid Disease	Anxiety/Depression
Psoriasis	Raynaud's Disease	Mental Health Problems
Blistering Sunburns	High Blood Pressure	Convulsions/Seizures
HIV/AIDS	Irregular Heartbeat	Kidney Disease
Hepatitis	Heart Murmur	Bladder
Bad Scars/Keloids	Heart Attack, Disease	Stomach
Asthma	Chest Pain	Bowel
Hay Fever	Pacemaker/defibrillator	Lupus/Tissue Disease
Diabetes	Bleeding Problems	Loss of Vision
Fever	Artificial Heart Valve	Glaucoma
Weight Loss	Damaged Heart Valve	Muscle Aches
Diarrhea	Lung Disease	Arthritis/Joint Problems
Hearing Loss	Poor Circulation	Easy Bruising
Throat Pain	Cold Intolerance	Headaches
Anemia		Fainting
Male	Female	Artificial Joints
Penile Discharge	Breastfeeding	If yes, what joint (s)_____
Lesions	Breast Mass	Cancer
	Discharge	If yes, type_____

What is your occupation? _____

Do you have any hobbies? _____

Are you currently pregnant? _____

Are you currently pregnant? ☐ NO ☐ YES If yes, how many weeks? _____

Do you have any pets? ☐ NO ☐ YES If yes, what kind? _____

Do you use sunscreen? ☐ NO ☐ YES

Do you use a tanning booth? ☐ NO ☐ YES If yes, how often? _____

When you are exposed to the sun, do you ☐ tan ☐ tan and burn ☐ burn?

Do you use tobacco products? ☐ NO ☐ YES Amount_____

Do you drink alcohol? ☐ NO ☐ YES Amount_____

BIRTH SEX: ☐ *Male* ☐ *Female* ☐ *Unknown*

GENDER IDENTITY

☐ Male
☐ Female
☐ Female-to-Male (FTM) / Transgender Male / Trans Man
☐ Male-to- Female (MTF) / Transgender Female / Trans Woman
☐ Additional Gender Category or other, Please Specify: _____
☐ Choose not to disclose

MEDICAL TEAM USE ONLY
REVIEWED BY: _____