PARKS DERMATOLOGY CENTER

400 Lakebridge Plaza Drive • Ormond Beach, Florida 32174
Telephone: 386-677-9044 • Fax 386-677-3083

Name ______________________ Date ______________

Prefer to be called ______________________ Date of Birth ______________

Occupation ______________________ SS# ______________

What are you seeing the doctor for today? ______________________

When did the problem begin? ______________________

What have you tried in the past? ______________________ Did it help? ☐ Yes ☐ No

List any allergies to medicines: ☐ None 1. ______________ Reaction ______________

List allergies to: rubber, latex, nickel, foods, flowers, plants, weeds, etc. ______________

Medications you take or apply (including eye drops) ☐ None

1. ______________ 3. ______________

2. ______________ 4. ______________

YES	NO	
☐	☐	Aspirin
☐	☐	OTC Products *(such as: vitamins, Tylenol, laxatives, etc.)*
☐	☐	Anti-inflammatory (eg. Advil, Motrin)
☐	☐	Do you use tobacco? If yes, how much, _________ packs per day
☐	☐	Do you drink alcohol? If yes, how much ___________ drinks per day/week/month

YES	NO	
☐	☐	Do you use recreational drugs? If yes, which drugs? ______________
☐	☐	Have you ever had skin cancer? If yes, type ______________
☐	☐	Has anyone in your family ever had skin cancer?
☐	☐	Have you ever had melanoma?
☐	☐	Has anyone in your family had melanoma?

Do YOU have or have you ever been diagnosed with any of the following medical conditions?

YES	NO	
☐	☐	High Blood Pressure
☐	☐	Heart Disease
☐	☐	Angina, Heart Attack
☐	☐	Murmur
☐	☐	Mitral valve prolapse
☐	☐	Pacemaker
☐	☐	Artificial Valves
☐	☐	Faint Easily
☐	☐	Stroke, paralysis
☐	☐	Blood clots
☐	☐	Auto Immune Disease

YES	NO	
☐	☐	Anemia
☐	☐	Lung Disease
☐	☐	Asthma
☐	☐	Hay fever, sinus/allergy
☐	☐	Tuberculosis
☐	☐	HIV
☐	☐	Gastrointestinal Disorder
☐	☐	Ulcers
☐	☐	Hepatitis/Jaundice
☐	☐	Liver problems
☐	☐	Kidney disease
☐	☐	Lupus

YES	NO	
☐	☐	Diabetes (sugar)
☐	☐	Thyroid problems
☐	☐	Irregular periods
☐	☐	Excess hair growth
☐	☐	Keloids/Abnormal Scarring
☐	☐	Cataracts or Glaucoma
☐	☐	Cancer, type ______________
☐	☐	Artificial joints
☐	☐	Joint pain, which joints _____
☐	☐	Trouble urinating
☐	☐	Nervous/Mental problems
☐	☐	Arthritis

Who is your primary physician ______________________

Name of pharmacy ______________________

Do you have a prescription plan through your ins. ______________________

FEMALES

☐	☐	Are you taking birth controls?
☐	☐	Are you pregnant now or considering pregnancy?
☐	☐	Are you breast feeding?

☐ ☐ Did a doctor refer you to our clinic? If yes, their name ______________________

Is there anything else the doctor should know? ______________________

Do we have your permission to:

Leave a message on your answering machine at home?	☐ Y	☐ N
Leave a message at your place of employment?	☐ Y	☐ N
Discuss your medical condition with any member of your household?	☐ Y	☐ N

If yes, whom: ______________________ Relationship ______________________

______________________ ______________________

Patient Signature Date