

**NORTHEAST TARRANT DERMATOLOGY, INC.**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

**FAMILY HISTORY**  
(PLEASE MARK ALL THAT APPLY)

- |                                    |                                      |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HAIR LOSS   |
| <input type="checkbox"/> ASTHMA    | <input type="checkbox"/> HAY FEVER   |
| <input type="checkbox"/> CANCER    | <input type="checkbox"/> PSORIASIS   |
| <input type="checkbox"/> DIABETES  | <input type="checkbox"/> SKIN CANCER |
| <input type="checkbox"/> ECZEMA    | <input type="checkbox"/> OTHER _____ |

**PATIENT'S PAST MEDICAL HISTORY**  
(PLEASE MARK ALL THAT APPLY)

- |   |   |
|---|---|
| <input type="checkbox"/> AIDS RISK  | <input type="checkbox"/> LUNG DISEASE                     |
| <input type="checkbox"/> ANEMIA   | <input type="checkbox"/> LUPUS                            |
| <input type="checkbox"/> ARTHRITIS  | <input type="checkbox"/> NEUROLOGICAL DISEASE             |
| <input type="checkbox"/> ASTHMA   | <input type="checkbox"/> PREVIOUS SURGERY                 |
| <input type="checkbox"/> BLEEDING DISORDER  | <input type="checkbox"/> PSORIASIS                        |
| <input type="checkbox"/> CANCER Type: _____   | <input type="checkbox"/> RECENT WEIGHT LOSS/ GAIN         |
| <input type="checkbox"/> CORONARY HEART DISEASE   | <input type="checkbox"/> SEIZURES                         |
| <input type="checkbox"/> DIABETES   | <input type="checkbox"/> SKIN CANCER (including melanoma) |
| <input type="checkbox"/> ECZEMA   | <input type="checkbox"/> OTHER: _____                     |
| <input type="checkbox"/> HAIR LOSS <input type="checkbox"/> Progressive <input type="checkbox"/> Recent | <input type="checkbox"/> X-RAY THERAPY                    |
| <input type="checkbox"/> HAY FEVER  |   |
| <input type="checkbox"/> HEADACHE/ MIGRAINE   |   |
| <input type="checkbox"/> HEPATITIS  | <b>FEMALES</b>  |
| <input type="checkbox"/> HERPES   | <input type="checkbox"/> BIRTH CONTROL                    |
| <input type="checkbox"/> HIVES  | <input type="checkbox"/> CURRENTLY PREGNANT               |
| <input type="checkbox"/> HYPERTENSION   | <input type="checkbox"/> IRREGULAR MENSTRUATION           |
| <input type="checkbox"/> KELOIDS  |   |
| <input type="checkbox"/> KIDNEY DISEASE   |   |

**CURRENT MEDICATIONS**

_____	_____
_____	_____
_____	_____

**HABITS**

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> CIGARETTES   | <input type="checkbox"/> COFFEE/TEA       |
| <input type="checkbox"/> ALCOHOL      | <input type="checkbox"/> REGULAR EXERCISE |
| <input type="checkbox"/> STREET DRUGS |   |

**DRUG ALLERGIES**

_____	_____
_____	_____