BURNETT DERMATOLOGY

1545 Mound Street ~ Sarasota, Florida 34236 ~ 941~957~3376

PHYSICAL HISTORY FORM

Name:_____ **Date of Birth:** _____

Past Medical History: (please list current and past medical problems)_____

_____

Past Surgical History: _____

Skin Disease History: (please circle all that apply)

Acne	Dry skin	Poison IVY
Actinic Keratoses	Eczema	Pre-cancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin cancer
Blistering Sunburns	Malignant Melanoma	None

0ther:_____

- Do you wear Sunscreen? Yes _____ No _____
- If yes, what is the SPF number you apply _____
- Do you tan in a tanning salon? Yes _____ No _____
- Do you have a family history of Melanoma? Yes _____ No _____
- If yes, what relationship to the relative(s)? _____

Medications: (Please enter all **current** medications)

_____

Medication Allergies: (Please enter all **medications** allergies only)

_____

Cigarette Smoking: (Please check one)

☐ Currently Smokes ☐ Never smoked ☐ Former smoker

REVIEW OF SYSTEMS:

Are you currently experiencing any of the following?
(Please circle all that apply)

Rash	Fever or chills
Issues with healing	Immunosuppressant
Issues with bleeding	Issues with scarring

ALERTS:

(Please circle all that apply)

Allergy to Adhesive: Yes _____ No _____
Allergy to lidocaine: Yes _____ No _____
Allergy to ***topical*** antibiotics: Yes _____ No _____
Defibulator: Yes_____ No _____
Pacemaker: Yes _____ No_____
Artificial heart valve: Yes _____ No _____
Artificial joint replacement: Yes _____ No _____
Require antibiotics prior to a surgical procedure: Yes _____ No _____
Are you pregnant or trying to get pregnant? Yes _____ No_____
Do you experience a ***rapid heartbeat*** with epinephrine? Yes _____ No _____

FAMILY HISTORY:

Race: _____ Ethnicity: (circle one) Hispanic or non-Hispanic

PHARMACY INFORMATION: (required)

Preferred pharmacy Name and Location:

_____

Pharmacy Phone#: _____

City and Zip code: _____