



## Skin Disease History

1. Do you wear Sunscreen?  Yes,  No      If Yes, what SPF value: \_\_\_\_\_

2. Have you had any of the following:

Acne:  Yes,  No

Atypical Moles:  Yes,  No

Actinic Keratosis:  Yes,  No

Psoriasis:  Yes,  No

Basal Cell Carcinoma:  Yes,  No

Squamous Cell Carcinoma:  Yes,  No

Eczema, Flaking skin:  Yes,  No

Flaking Scalp, Dandruff :  Yes,  No

Poison Ivy History:  Yes,  No

Contact Dermatitis:  Yes,  No

Precancerous Moles:  Yes,  No

History of Melanoma:  Yes,  No

Hay Fever, Allergies:  Yes,  No

Sunburn History:  Yes,  No

Sunburns? How Many: \_\_\_\_\_

**Other Skin Conditions:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Do you have family history of melanoma?  Yes,  No      If so, who? \_\_\_\_\_

4. Do you or have you used tanning beds?  Yes,  No      If Yes, how often: \_\_\_\_\_

5. When was your last skin check and where? \_\_\_\_\_

6. Are you interested in cosmetics (Example: Botox, Fillers, Ulthera, etc)?  Yes,  No

7. I am interested in the following cosmetic procedures: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. If you have had cosmetic procedures performed, please list: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Date:** \_\_\_\_\_      **Printed Name of Patient:** \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_