

___ New Pt ___ Update

Phoebe Rich Dermatology

2565 NW Lovejoy Suite 200 Portland, OR 97210 503-226-3376

Name _____ Today's Date _____

Preferred pronouns _____ Age _____

▪Purpose of today's visit: _____

▪Who were you referred by? _____

▪Who is your primary care doctor? _____ Height _____ Weight _____

Please list medications or attach current medication list:

Current Medications	Approximate Start Date	Reason for taking medication

▪ Do you have a **PERSONAL HISTORY** of pre-cancerous skin lesions (actinic keratoses) or skin cancer (basal cell carcinoma, squamous cell carcinoma or melanoma)? ☐ YES ☐ NO

If yes, please list skin cancer type(s) location, and approximate date of diagnosis:

▪ Please list any **OTHER HEALTH CONDITIONS** you have. Include skin conditions, cancer, diabetes, heart disease, autoimmune disease, bleeding/clotting problems, depression/anxiety, etc.

Are you or is there any chance that you might be pregnant? ☐ YES ☐ NO

Are you nursing? ☐ YES ☐ NO

▪ **Do you have any MEDICATION ALLERGIES (ex antibiotics, lidocaine, epinephrine, latex)?**

☐ YES

☐ NO KNOWN MEDICATION ALLERGIES

If yes, please list the name of medication and type of reaction you experienced:

▪ **Please list all significant SURGERIES AND HOSPITALIZATIONS and approximate dates:**

▪ **Do you have a FAMILY HISTORY of basal cell carcinoma, squamous cell carcinoma, or an unknown type of skin cancer?** ☐ YES ☐ NO

▪ **Do you have a FAMILY HISTORY of melanoma?** ☐ YES ☐ NO

If yes, please list relationship of family member (s) who had melanoma:

Sun History:

▪ **How much sun exposure have you had?** ☐ MINIMAL ☐ MODERATE ☐ EXTREME

▪ **Have you ever had a blistering sunburn?** ☐ YES ☐ NO

▪ **Tanning bed use?** ☐ YES ☐ NO ☐ History of tanning bed use

▪ **Sunscreen Use:** ☐ Daily ☐ Sometimes ☐ When going outdoors ☐ Other _____

▪ **Smoking habits:** ☐ Currently a smoker ☐ Former smoker ☐ Never smoked

▪ **Recreational drug use?** _____ ▪ **Medicinal marijuana use?** _____

▪ **What is your occupation?** _____ ▪ **Where did you grow up?** _____

Patient Signature _____ MD/PA Signature _____

By printing your name above, you indicate you have completed this form to the best of your knowledge.