Providence Medical Group/Glisan Dermatologic Specialties
5330 NE Glisan Street, Suite 200
Portland, OR 97213

Dermatology Patient History Form

Name: _____ Today's Date: _____

Date of Birth: _____

Primary Care Physician: _____ Referring Provider: _____

Primary skin concern: _____

Location: _____
How long have you had this problem? _____
What have you used to treat it? _____
Other Skin Concerns: _____
_____
_____
_____

Current Symptoms:

Fever/Chills	Kidney Problems	Cough	Stomach/Bowel problems
Eye Problems	Arthritis	Shortness of breath	Seizures
Chest Pain	Depression/Anxiety	Leg Swelling	Other **NONE**

Other Symptoms: _____

Personal Medical Problems:

Melanoma	Yes	No	Comments _____
Basal/Squamous cell carcinoma	Yes	No	Comments _____
Eczema	Yes	No	Comments _____
Asthma	Yes	No	Comments _____
Hay fever/allergies	Yes	No	Comments _____
Excessive bruising or bleeding	Yes	No	Comments _____
Keloids/scarring	Yes	No	Comments _____
Allergic to latex or rubber	Yes	No	Comments _____
Allergic to tape/bandages	Yes	No	Comments _____
Diabetes	Yes	No	Comments _____
Heart disease	Yes	No	Comments _____
Hepatitis or liver disease	Yes	No	Comments _____
HIV disease	Yes	No	Comments _____
Immunosuppression/Organ transplant	Yes	No	Comments _____
Gastrointestinal disease	Yes	No	Comments _____
Kidney disease	Yes	No	Comments _____
Cancer	Yes	No	Comments _____

Family Medical History:

Prior Surgeries:

SEE REVERSE

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Family Hx of melanoma	Yes	No
Tanning Bed Use	Yes	No
Pregnant	Yes	No
Trying to get pregnant	Yes	No
Breastfeeding	Yes	No
Artificial Joints or heart valves	Yes	No
Tobacco use	Yes	No
Alcohol use	Yes	No

Occupation: _____

Allergies: _____

Medications: _____

_____

_____

_____

_____

_____

Hobbies: _____