HELEN SHIM, M.D., PLLC

DERMATOLOGY/DERMATOPATHOLOGY

Patient Name: _____ Age_____ DOB_____ Height_____ Weight _____

Primary Care Physician _____ Allergies: _____ Latex __ Y __ N

Reason for Visit: _____

Medical Problems or Conditions: _____

	Yes	No	Details/Who
Have you ever had skin cancer?			
Have you ever had melanoma?			
History of any skin disorders?			
History of tanning bed use?			
History of blistering sun burns?			
Anyone in the family with any skin cancer or melanoma?			
Anyone in the family with any skin problems?			

(Women): Are you pregnant? Yes __ No ___ Planning to become pregnant? Yes __ No ___
Current Medications (including supplements, herbs, vitamins): _____

_____

Surgical Procedures you have had: _____

Heart valve replacement ___ Yes (Year _____) __ No **Knee Replacement** ___ Yes (Year _____) ___ No

Do you smoke? ___ Yes ___ No If YES, how many cigarettes per day? _____

Do you drink alcohol? ___ Yes ___ No If YES, how many drinks per day? _____

Do you, or have you used IV drugs? ___ Yes ___ No What is your occupation? _____

Review of Systems: Current or past problems with:

	Yes	No		Yes	No		Yes	No
Thyroid			Stomach/Bowel			General Health		
Lungs			Joints			Allergic Reactions		
Diabetes			Muscles			Blood/Bleeding Disorder		
Eyes			Heart			Liver		
Pacemaker			Asthma			Psychological Disorder		
Kidneys			Seizures			Heart Valves		
Skin			Artificial Joints			Dialysis		
Ears/Nose			Throat/Mouth					

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