RoxyAnn Dermatology

Patient Name:_____ **Date of Birth**_____.

Preferred Pharmacy: Name: _____ **Location:** _____.

Reason for visit: _____.

Past Medical History:

Skin Cancer History:
Basal Cell Carcinoma: Yes:_____**No**_____**If yes, Location:**_____.
Squamous Cell Carcinoma: Yes_____**No**_____**If yes, Location:**_____.
Melanoma: Yes:_____**No:**_____**If yes, Location**_____.

Other:

Do you wear Sunscreen: Yes:_____**. No:**_____**. If yes, what SPF?**_____.

Do you tan at a tanning salon? Yes:_____**. No:**_____**. How often?**_____.

Do you have a family history of Melanoma?_____.

If yes, which relative(s):_____.

Current Medications:

Do we have permission to upload a list of your medications from your pharmacy? Yes:_____**No:**____**(initial)**

Turn: 

Drug Allergies:

Alerts, i.e.: Adhesives, topical antibiotics, blood thinners/Aspirin (circle): Other:_____.

Smoking History: Current smoker:_____. Former smoker:_____. Never smoked:_____.

For Patients 65 and older:

Have you received a pneumonia vaccination? Yes:_____. No:_____.

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes:_____No_____.

Do you have a living will? Yes:_____. No:_____.

For all Patients:

Have you had the Flu Vaccine during the Flu season (between August 2020 and March 2021)?

Yes:_____. No:_____.

Height:_____.

Weight:_____.

The information provided within this form is true, and correct, to the best of my knowledge.

Signature of Patient/Responsible Party:_____

Print Name: _____ Date: _____