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NAME: _____ AGE: _____ DATE: _____

MANY SKIN PROBLEMS ARE CAUSED BY OR AFFECTED BY INTERNAL MEDICAL DISORDERS. TREATMENT MAY ALSO BE CHANGED DEPENDING ON OTHER MEDICAL DISORDERS YOU HAVE. FOR THIS REASON, IT IS IMPORTANT THAT WE KNOW ABOUT YOUR GENERAL HEALTH.

MEDICAL HISTORY

Please list your medical problems that have been diagnosed or treated by a physician now or in the past (for example: diabetes, cancer, thyroid, angina, high blood pressure, kidney, anemia, depression, surgeries, or hospitalizations, etc).

MEDICATIONS

Please list all prescription and non-prescription drugs or medications that you use (including aspirin):

Have you taken any pain relieving medicine or arthritis medicine in the last two weeks?

ALLERGIES TO MEDICATIONS

Are you allergic to any pills, shots, or medicine applied to your skin?

FAMILY HISTORY

Have any relatives had:

Similar skin problems?	NO	YES	WHO?	_____
Asthma or hay fever?	NO	YES	WHO?	_____
Eczema?	NO	YES	WHO?	_____
Malignant melanoma?	NO	YES	WHO?	_____
Other skin diseases? If yes, what type?	NO	YES	WHO?	_____
Other diseases? If yes, what type?	NO	YES	WHO?	_____

SOCIAL HISTORY

What is your job? _____

What do you do for hobbies? _____

Do you wear sunscreen when you are outdoors? _____

MEDICAL SYSTEM REVIEW

Are you currently experiencing problems with any other parts of your body, such as weight loss/gain, joint aches, headaches, sores that won't heal, lumps or swelling, or any other problems?