Carla J Bauman Medical and Cosmetic Dermatology CB SK AN JR
626 120th Ave NE Suite B104 Bellevue, WA 98005
P: 425-455-3376 F: 425-455-2766 Web: www.cjbmd.com

PLEASE COMPLETE ENTIRE FORM PRIOR TO APPOINTMENT

Patient: _____ Date of Birth: ___/___/___ Today's Date: ___/___/___

Retail or Mail-order Pharmacy Information:_____
Name Location Phone

Primary Care Physician:_____
Name Location Phone

Referring Physician:_____
Name Location Phone

Reason for Today's Visit:_____

Surgical History:_____

Currently Pregnant: □ Yes □ No Due Date: ___/___/___ Currently Breast Feeding: □ Yes □ No

Are you planning a pregnancy in the next year: □ Yes □ No

Are you allergic to any medications? □ YES □ NO If yes, please list:_____

Have you ever had Dental Anesthesia (Lidocaine/Epinephrine)? □ YES □ NO Any bad reaction? □ YES □ NO

Healing Problems: □ YES □ NO

List all medications you are currently taking (include current dose):

_____

_____

Personal/Past Medical History: SELECT ALL THAT APPLY

Height_____ Weight_____

History of: **Cancer and/or on current method of treatment:**_____

Social History: SELECT ALL THAT APPLY

Do you drink alcohol? □ YES □ NO If YES _____ drinks per day

Do you use recreational drugs? □ YES □ NO If YES, *what & how often*:_____

Smoking Status**:** □Current everyday □Current some day's □Former □Never □Unknown if ever smoked

Type: □Smokeless □Cigars □Cigarettes □Marijuana

For how long:_____

Do you use a tanning bed? □YES □NO Frequency:_____

Do you tan outside? □YES □NO Frequency:_____

Do you use sunscreen? □YES □ NO

Family History: SELECT ALL THAT APPLY

□ Basal Cell □ Squamous Cell □ Melanoma □ Skin Cancer (unknown type)

□ Acne □ Psoriasis □ Hair Loss □ Several Moles □ Skin Rashes

Please list any other significant Family Medical History:_____

Review of Systems: SELECT ALL THAT APPLY

Natural/Original Hair Color: □ Black □ Brown □ Light Brown □ Blonde □ Red

Natural Eye Color: □ Black □ Brown □ Light Brown □Blue □ Hazel □ Gray □ Green □ Red

Skin Color: □ Very Pale □ Fair □ Med-Olive □ Dark □Olive Brown □ Brown □ Black

INFECTIOUS

Tuberculosis □ Yes □ No
HIV/Aids □ Yes □ No
Hepatitis B or C □ Yes □ No
Herpes □ Yes □ No

GYNECOLOGY

Irregular Menstrual Cycle □ Yes □ No
Menopause □ Yes □ No
Pregnancy □ Yes □ No
Miscarriages □ Yes □ No

CARDIOLOGY

Heart Murmur □ Yes □ No
Heart Valve □ Yes □ No
Pacemaker □ Yes □ No
High/Low Blood Pressure □ Yes □ No
Varicose Veins □ Yes □ No
Artery Disease □ Yes □ No
Stent/Bypass □ Yes □ No

EYES, EARS, NOSE & THROAT

Dry Mouth □ Yes □ No
Glaucoma □ Yes □ No
Sinus Infections □ Yes □ No
Cataracts □ Yes □ No

ENDOCRINOLOGY

Diabetes □ Yes □ No
Thyroid Disease □ Yes □ No

OVER >>>>>>>>

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CB SK AN JR

MUSCULOSKELETAL

Artificial Joints ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Gout ☐ Yes ☐ No
Lupus ☐ Yes ☐ No

UROLOGY

Kidney Disease ☐ Yes ☐ No
Dialysis ☐ Yes ☐ No

RESPIRATORY

Asthma ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No
Sacoidosis ☐ Yes ☐ No
Abnormal Chest X-Ray ☐ Yes ☐ No
Seasonal Allergies ☐ Yes ☐ No

HEMATOLOGY

Anemia ☐ Yes ☐ No
Low WBC ☐ Yes ☐ No
Blood Clots ☐ Yes ☐ No
Lymphoma ☐ Yes ☐ No
Leukemia ☐ Yes ☐ No
Sickle Cell Anemia ☐ Yes ☐ No
Excessive Bleeding ☐ Yes ☐ No

GASTROENTEROLOGY

Stomach Ulcers ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Crohn's Disease ☐ Yes ☐ No

PSYCHOLOGY

Depression ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Bulimia/Anorexia ☐ Yes ☐ No
Chemical Dependency ☐ Yes ☐ No

NEUROLOGY

Seizures ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Multiple Sclerosis ☐ Yes ☐ No

DERMATOLOGY

Acne ☐ Yes ☐ No
Eczema ☐ Yes ☐ No
Psoriasis ☐ Yes ☐ No
Nail Problems ☐ Yes ☐ No
Hair Loss ☐ Yes ☐ No
Sun Sensitivity ☐ Yes ☐ No
Reaction to Jewelry ☐ Yes ☐ No
Rosacea ☐ Yes ☐ No
Scars/Keloids ☐ Yes ☐ No
Cold Sores ☐ Yes ☐ No
Warts ☐ Yes ☐ No
Genital Warts ☐ Yes ☐ No

List CURRENT Symptoms:

SKIN

Changing Moles ☐YES ☐NO
Itching ☐YES ☐NO
Burning ☐YES ☐NO
Welts ☐YES ☐NO
Hives ☐YES ☐NO
Sores ☐YES ☐NO

CONSTITUTIONAL

Fever ☐YES ☐NO
Night sweats ☐YES ☐NO
Chills ☐YES ☐NO
Weight changes ☐YES ☐NO

CARDIAC

Chest pain ☐YES ☐NO
Irregular heart beat ☐YES ☐NO

EAR NOSE THROAT

Sores ☐YES ☐NO
Growths ☐YES ☐NO
Sinus Problems ☐YES ☐NO
Difficulty Swallowing ☐ Yes ☐ No

GASTROINTESTINAL

Abdominal pain ☐YES ☐NO
Diarrhea ☐YES ☐NO

GENTOURINARY

Abnormal Urination ☐YES ☐NO
Genital discharge ☐YES ☐NO
Menstrual irregularities ☐YES ☐NO

HEMATOLOGIC

Bruise easily ☐YES ☐NO
Blood Clots ☐YES ☐NO

MUSCULOSKELETAL

Joint pain ☐YES ☐NO
Swelling ☐YES ☐NO
Muscle pain/weakness ☐YES ☐NO

NEUROLOGIC

Weakness ☐YES ☐NO
Numbness ☐YES ☐NO
Headaches ☐ Yes ☐ No

RESPIRATORY

Shortness of breath ☐YES ☐NO
Wheezing ☐YES ☐NO
Cough ☐YES ☐NO

ENDOCRINE

Cold/Heat intolerance ❑YES ❑NO

OTHER:_____

Authorization for telephone communication: Choose one of the following

____I authorize Carla J. Bauman M.D. staff to leave a message of non-sensitive nature that may contain protected health care information on my voicemail or answering machine. Phone number:_____

____I authorize Carla J. Bauman M.D. staff to leave a message or communicate details of my Dermatology care that may contain protected health care information with:_____

LAST, FIRST RELATIONSHIP PHONE

____I do not authorize Carla J. Bauman staff to leave a message containing protected health care information

_____ _____ _____ ___/___/___

PRINT PATIENT NAME PATIENT OR AUTHORIZED LEGAL SIGNATURE RELATIONSHIP TO PATIENT DATE