Patient Name:	**DOB:**

Skin Disease History (Please check all that apply)

- ☐ Pre cancers ☐ Melanoma ☐ Hay fever/allergies ☐ Eczema/Rash
- ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Asthma ☐ Keloids

Past Medical History (Please check all that apply)

☐ Anxiety	☐ Depression	☐ HIV/AIDS
☐ Arthritis	☐ Diabetes	☐ Pacemaker
☐ Artificial Joints	☐ Hepatitis	☐ Thyroid Issues
☐ Cancer	☐ High Blood Pressure	

Family History (please check if immediate family)

☐ Allergies	☐ Cancer	☐ High Blood Pressure
☐ Asthma	☐ Eczema/Rash	☐ Melanoma

Medication List

RX:	Dosage:
RX:	Dosage:
RX:	Dosage:
RX:	Dosage:
RX:	Dosage:

Allergies

Allergy:	Reaction:
Allergy:	Reaction:
Allergy:	Reaction:

Social History

Do you wear sunscreen? Yes No	Have you smoked cigarettes in the past? Yes No
Do you tan in a tanning salon? Yes No	Do you drink alcohol? Yes No
Do you currently smoke cigarettes? Yes No	If yes how many alcohol drinks per week?______

Pharmacy Information

Pharmacy Name:	Phone Number:

Knowing that I am experiencing a condition that may require diagnostic, medical or surgical treatment, I do hereby voluntarily consent to such procedures, medical care, surgical or other services under the general and special instructions of Christopher Rex, assistants, designee, or other doctor and is judged necessary.
I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result in a brown, red, white, or depressed scar appearing in the area. I understand that the potential risks and benefits of surgery include the risk of infection, bleeding, injury to nerves, postoperative stiffness, pain, and failure of the surgery to achieve its intended goals. An infection is usually very swollen skin, which should be reported to the office immediately. I give consent for any picture to be taken for medical documentation purposes. I also acknowledge that treatments including chemical peels (TCA Solution), may result in redness, dryness, peeling skin, and possible chemical burns, which should improve over time.
Please be advised that if you do not wish to sign the consent form, the doctor(s) and or their assistants will not be able to treat you for any condition. Arizona Institute of Dermatology shares medical records with your primary care and or specialty doctors so that we can provide the very best care for you.

_____________________________________ _______________________________

Signature of Patient/or Guardian Date