Dermatology of the Berkshires pc
VICTORIA R. CAVALLI, M.D. BOARD CERTIFIED DERMATOLOGIST

MEDICAL INFORMATION SHEET

Name: _____ DOB: _____ Age: _____ Date: _____

Primary Care Physician: _____

Reason for dermatology visit: _____

Do you have a current history or past history of any of the following medical conditions? Check any that apply.

□Heart disease	□High blood pressure	□Lung disease	□Liver disease	□Arthritis
□Kidney disease	□Peptic ulcers	□Diabetes	□Eye diseases	□Cancer
□Depression	□Anxiety	□Blood	□Autoimmune	□Lymph disease

Other: _____

Have you ever tested positive for Hepatitis, HIV, Tuberculosis or Syphilis? _____

Please list any surgeries with approximate dates: _____

_____

What prescription medications, over-the-counter remedies, herbal or dietary supplements do you take?
(PLEASE BRING A PRINTED LIST IF POSSIBLE) _____

_____

Are you allergic to any drugs? _____ If yes, please list: _____

Occupation: _____ Hobbies: _____

Do any diseases run in your family (skin cancer, eczema, asthma, hay fever, psoriasis)? _____

_____

Do you smoke tobacco? _____ If so, how much? _____
Do you drink alcohol? _____ If so, how much? _____

For women: Are you pregnant or nursing? _____
Date of your last period: _____
Please inform the doctor if you plan to or become pregnant during treatment.

I have come to this office for evaluation of a skin condition and give permission for examination and treatment by the provider(s) of Dermatology of the Berkshires, P.C.

Signature: _____ Date: _____