

# Dermatology of the Berkshires, P.C.

Victoria R. Cavalli, M.D.

40 Main Street · North Adams, MA 01247 · (413)663-6769

## 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.

- |   |  |                                       |  |  |
|---|--|---------------------------------------|--|--|
| <input type="checkbox"/> Heart disease  | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Arthritis     |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Peptic ulcers       | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Eye diseases  | <input type="checkbox"/> Cancer        |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Blood        | <input type="checkbox"/> Autoimmune    | <input type="checkbox"/> 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? \_\_\_\_\_

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 Victoria Cavalli, M.D. and/or Amy Gumprecht, PA-C.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_