

**JEFF ALEXANDER, MD**  
**ASHLEY BIGGS, MA, PA-C**  
DERMATOLOGY CLINIC ❖ MEDICAL SPA

Please print \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Day phone \_\_\_\_\_ Evening phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Please list any medications you take regularly: \_\_\_\_\_

Please list any allergies to medications: \_\_\_\_\_

	Yes	No
Are you pregnant or breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or any family members had melanoma?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an artificial joint or heart valve?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take antibiotics before surgery or dental work?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of—		
Bleeding/blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal scarring	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
Do you take—		
Aspirin (enteric-coated/cold remedies)	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners (Warfarin/Coumadin)	<input type="checkbox"/>	<input type="checkbox"/>
Steroids (Prednisone/Cortisone)	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to—		
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetic (including dental anesthetic)	<input type="checkbox"/>	<input type="checkbox"/>
Creams/ointments	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Tape/bandages	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the above, please provide detail regarding each specific disorder/allergy, including any drugs taken in the treatment of same. Also, provide detail regarding any other disorder/allergy/drug used not mentioned above:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Pharmacy Phone Number \_\_\_\_\_

Location \_\_\_\_\_