REN DERMATOLOGY (615) 835-3220

NAME:_____ DATE OF BIRTH:_____

How did you hear about us? _____

Reason for today's visit: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis B, Hepatitis C
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

Other _____

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Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all current medications)

Name: Dosage:

_____

_____

_____

_____

Allergies: (Please enter all allergies and the reaction you experienced)

_____

Social History: (Please circle all that apply)

Cigarette Smoking:	Alcohol Use:	Sexual Activity
Never smoked	YES	Not sexually active
Quit: former smoker	NO	Sexually active with one partner
Smokes less than daily		Sexually active with more than one partner
Smokes daily		Same sex partner

How often do you exercise?	What is your caffeine use?	Recreational IV drug use?
Once a day	Once a day	YES
A few times a week	A few times a week	NO
A few times a month	A few times a month	
Never	Never	

Occupation and Workplace_____

Review of Systems: (Please circle all that apply)

Problems with bleeding	Problems with Healing	Problems with scarring
History of Rash	Headaches	Artificial heart valve
Artificial joints	Blood Thinners	Defibrillator
Joint Aches	Pacemaker	

Pregnant or planning on becoming pregnant (circle one): Yes No

Family History: (ex. Diabetes, Hypertension, Breast Cancer)

_____

_____

Pharmacy: Name:_____Location:_____

Phone Number:_____