REN Dermatology

NAME:____ **DATE OF BIRTH:**____________________________

How did you hear about us? ________________________________ **Primary Care Physician:** ___________________________

Reason for today's visit: ____

Past Medical History: (please circle all that apply)

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

Other ____

Past Surgical History: (please circle all that apply)

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

Other ____

Skin Disease History: (please circle all that apply)

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

Other ____

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: ____

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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?	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)

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Pharmacy: Name:______________________________Location:____________________________

Phone Number:____

Treatment of Minors

I, ________________________________, give my permission to REN Dermatology to treat ______________________________.
(Mother, Father, Legal Guardian) (Name)

____ __________________________
(Signature) (Date)