REN Dermatology

NAME:_____ DATE OF BIRTH:_____

Primary Care Physician: _____

Reason for today's visit: _____

Preferred Pharmacy: Name: _____ Location: _____

Phone Number: _____

Past Medical History: (Please circle all that apply.)

Anxiety Disorder
Arthritis
Asthma
Atrial Fibrillation
Benign Prostatic Hyperplasia
Bone Marrow Transplant
Breast Cancer
Cerebrovascular Accident
Colon Cancer
COPD
Coronary Arteriosclerosis
Depressive Disorder
Diabetes Mellitus
Elevated blood pressure
End-Stage Renal Disease
Epilepsy
GERD
Hearing Loss
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Hepatitis
Leukemia
Lung Cancer
Malignant Lymphoma
Prostate Cancer
Radiation Treatment
None

Other _____

Past Surgical History: (Please circle all that apply.)

-Appendix Removed: (Appendectomy)
-Abdominoperineal Resection
-Replacement of Knee Joints: (Right, Left, or Bilateral)
-Biopsy of Breast
-Biopsy of Prostate
-Bladder Removed: Cystectomy
-Colectomy
-Coronary Artery Bypass Graft
-Entire Transplanted Kidney
-Excision: Basal Cell Carcinoma
-Excision: Melanoma
-Excision: Squamous Cell Carcinoma
-Gallbladder Removed: Cholecystectomy
-History of Colostomy
-Mastectomy: (Right, Left, or Bilateral)
-History of Liver Excision
-History of Percutaneous Transluminal Coronary Angioplasty
-History of Tissue Graft Heart Valve Replacement
-History of TURP
-Hysterectomy
-Kidney Biopsy
-Low Anterior Resection of Rectum
-Lumpectomy of Breast (Right, Left, or Bilateral)
-Mechanical Heart Valve Replacement
-Oophorectomy
-Pancreatectomy
-Percutaneous Extraction of Kidney Stone with Fragmentation Procedure
-Prostatectomy
-Prosthetic Arthroplasty of Bilateral Hips
-Splenectomy
-Surgical Biopsy of Skin
-Total Orchidectomy
-Total Replacement of Hip Joint: (Right, Left, or Bilateral)
-Total Replacement of Knee Joint: (Right, Left, or Bilateral)
-Transplantation of Heart
-Transplantation of Liver
None

Other _____

Skin Disease History: (Please circle all that apply.)

Acne
Actinic Keratosis
Asteatosis Cutis
Basal Cell Carcinoma of Skin
Contact Dermatitis due to Poison Ivy
Dysplastic/Atypical Mole (Nevus)
Eczema
History of Asthma
History of Hay Fever
Itchy Scalp (Pruritus)
Malignant Melanoma
Psoriasis
Squamous Cell Carcinoma of Skin
Sunburn of Second Degree
None

REN Dermatology

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)? _____

Medications: (Please list all current medications below – name and dosage.)

Name: Dosage:

_____

_____

_____

Allergies: (Please list all allergies and reactions if known.)

_____

Social History: (Please choose one option per question.)

Smoking Habits:
-Current every day smoker
-Current some day smoker: tobacco or cigarette
-Never smoker
-Cigar smoker
-Heavy tobacco smoker
-Light tobacco smoker

Alcohol Use:
-None
-Less than 1 drink per day
-1-2 drinks per day
-3 or more drinks per day

Sexually Active?
-No
-Yes, one partner
-Yes, multiple partners
-Is your partner the same gender as yourself? _____

How often do you exercise?
-Several times a day
-Once a day
-A few times a week
-A few times a month
-Never

Caffeine use?
-Several times a day
-Once a day
-A few times a week
-A few times a month
-Never

Illicit drug use?
-No
-Yes

Occupation and Workplace _____

Review of Systems: (Please circle all that apply)

Problems with bleeding
Problems with healing
Problems with scarring
Rash
Allergy to Adhesive
Allergy to Lidocaine
Allergy to Topical Abx Ointment
Artificial Heart Valve
Artificial Joints (Past two years)
Blood Thinners
MRSA
Pacemaker
Premedication prior to procedures
Rapid Heart Beat with Epinephrine

Pregnancy or planning a pregnancy? YES or NO

Family History: (Please include only first-degree relatives. Examples: Diabetes, Hypertension, Breast Cancer)

_____

_____