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

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)? _____

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:	Alcohol Use:	Sexually Active?
-Current every day smoker	-EtOH none	-No
-Current some day smoker: tobacco or cigarette	-EtOH less than 1 drink per day	-Yes, one partner -Yes, multiple partners
-Never smoker	-EtOH 1-2 drinks per day	-Is your partner the same gender as yourself? _____
-Cigar smoker	-EtOH 3 or more drinks per day	
-Heavy tobacco smoker		
-Light tobacco smoker		

How often do you exercise?	Caffeine use?	Illicit drug use?
-Several times a day	-Several times a day	-No
-Once a day	-Once a day	-Yes
-A few times a week	-A few times a week	
-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	Allergy to Lidocaine	MRSA
Problems with healing	Allergy to Topical Abx Ointment	Pacemaker
Problems with scarring	Artificial Heart Valve	Premedication prior to procedures
Rash	Artificial Joints (Past two years)	Rapid Heart Beat with Epinephrine
Allergy to Adhesive	Blood Thinners	

Pregnancy or planning a pregnancy? YES or NO

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

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