

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

Other _____

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

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

Other _____

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

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

Other _____

REN Dermatology

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.)

<u>Smoking Habits:</u> -Current every day smoker -Current some day smoker: tobacco or cigarette -Never smoker -Cigar smoker -Heavy tobacco smoker -Light tobacco smoker	<u>Alcohol Use:</u> -EtOH none -EtOH less than 1 drink per day -EtOH 1-2 drinks per day -EtOH 3 or more drinks per day	<u>Sexually Active?</u> -No -Yes, one partner -Yes, multiple partners -Is your partner the same gender as yourself? _____
<u>How often do you exercise?</u> -Several times a day -Once a day -A few times a week -A few times a month -Never	<u>Caffeine use?</u> -Several times a day -Once a day -A few times a week -A few times a month -Never	<u>Illicit drug use?</u> -No -Yes

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)

