REN Dermatology & LASER CENTER

NAME AND DATE OF BIRTH:
PCP:
PHARMACY (NAME AND LOCATION):

MEDICAL HISTORY: (please circle those that apply)

ANXIETY/DEPRESSION	BLEEDING DISORDER	HEARING LOSS	MULTIPLE SCLEROSIS
ARTHRITIS	CANCER – TYPE:	HEPATITIS	MYASTHENIA GRAVIS
ASTHMA	CLOTTING DISORDER/BLOOD CLOTS	HIV/AIDS	PACEMAKER
ATRIAL FIBRILLATION	EPILEPSY	HYPERTENSION	RENAL DISEASE

OTHER: ____

SURGICAL HISTORY: (please circle those that apply)

ARTIFICIAL HEART VALVE	EXCISION: BASAL CELL CARCINOMA	EXCISION: MELANOMA	MASTECTOMY
ARTIFICIAL JOINTS	EXCISION: DYSPLASTIC/ATYPICAL MOLE	EXCISION: SQUAMOUS CELL CARCINOMA	SURGICAL BIOPSY OF SKIN

OTHER: ____

SKIN DISEASE HISTORY: (please circle those that apply)

ACNE	ALLERGIC CONTACT DERMATITIS	DYSPLASTIC/ATYPICAL MOLES	MALIGNANT MELANOMA	SQUAMOUS CELL CARCINOMA
ACTINIC KERATOSES	BASAL CELL CARCINOMA	ECZEMA	PSORIASIS	NONE

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)? -
____

MEDICATION:

NAME:	DOSAGE:

ALLERGIES: (PLEASE LIST ALL ALLERGIES AND REACTIONS IF KNOWN)

Allergies: ____
-DID YOU HAVE A FLU VACCINATION THIS PAST FLU SEASON? YES/NO
-ARE YOU A FORMER OR CURRENT SMOKER? YES/NO
-IF YES, TOBACCO OR CIGARETTE AND HOW OFTEN? ____
-DO YOU DRINK ALCOHOL? YES/NO
-IF YES, LESS THAN 1 DRINK PER DAY, 1-2 DRINKS PER DAY, OR 3 OR MORE DRINKS PER DAY?
-DO YOU HAVE A HEALTHCARE PROXY (DESIGNATED PERSON TO MAKE MEDICAL DECISIONS ON YOUR BEHALF IF YOU'RE UNABLE)? YES/NO
-IF YES, LIST THEIR NAME AND TELEPHONE NUMBER: ____