SKIN WELLNESS
PHYSICIANS

Reason(s) for visit:

_____

_____

Referred By:

_____

Primary Care Doctor:

_____

PAST MEDICAL HISTORY:

Please CIRCLE if you have/had any of the following or check ☐ **NO CHANGE**

Anxiety
Arthritis
Asthma
Atrial Fibrillation
BPH
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
HIV/AIDS
High Blood Pressure
High Cholesterol
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Thyroid Problems:
Hypo ☐ Hyper ☐
NONE OF THE ABOVE

Other:_____

_____

PAST SURGICAL HISTORY:

Please CIRCLE all that apply or check ☐ **NO CHANGE**

Appendix removed
Bladder removed
Mastectomy: Right ☐ Left ☐ Both ☐
Lumpectomy: Right ☐ Left ☐ Both ☐
Breast Biopsy: Right ☐ Left ☐ Both ☐
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Mechanical Valve Replacement
Hysterectomy: Fibroids ☐ Uterine Cancer ☐
Organ Transplant: _____
What Organ_____
NONE OF THE ABOVE

Joint Replacement:
Knee: Right ☐ Left ☐ Both ☐
Hip: Right ☐ Left ☐ Both ☐
Shoulder: Right ☐ Left ☐ Both ☐
Kidney Biopsy: Right ☐ Left ☐ Both ☐
Ovaries Removed: Endometriosis ☐ Cyst ☐ Ovarian Cancer ☐
Prostate Removed
Gallbladder Removed
Spleen Removed
Coronary Artery Bypass
Biological Valve Replacement

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SKIN DISEASE HISTORY: Please CIRCLE all that apply or check ☐ **NO CHANGE**

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

Other:

_____

Do you wear Sunscreen? Yes No If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

FAMILY HISTORY OF SKIN DISEASE: (Please indicate which Family Member)

Melanoma: _____
Psoriasis: _____
Skin Cancer: _____
Eczema: _____
Keloids: _____
Other: _____

Other:

_____

_____

Do you have a cosmetic or antiaging concern (i.e. fine lines, loss of volume, texture)? ☐Y ☐N
Have you had a cosmetic or antiaging treatment in the past? (i.e. Botox, fillers, laser rejuvenation) ☐Y ☐N
Have you noticed a loss of vaginal lubrication, tone, and/or laxity? ☐Y ☐N

Name of Person Completing this form:

Patient Name (Printed) Relationship to patient Date

Signature

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REVIEW OF SYSTEMS: (Please CIRCLE if you have experienced any of the following in the **past 30 days**)

Itch
Irregular menses
Problems with bleeding
Problems with healing
Problems with scarring (hypertrophic/keloid)
Rash
Unintentional Weight Loss
Hay Fever
Joint Aches
Muscle Weakness
Wheezing
Night Sweats
Anxiety
Chest Pain
Fever or Chills
Thyroid Problems
Sore Throat
Blurry Vision
Abdominal Pain
Neck Stiffness
Headaches
Shortness of Breath
Depression
Cough
NONE OF THE ABOVE

OTHER: (Please CIRCLE all that apply)

Allergy to adhesive
Allergy to lidocaine
Allergy to topical antibiotic ointments
Allergy to betadine
History of Leukemia
History of Lymphoma
Currently taking prednisone
HIV/AIDS
Allergy to latex
Artificial heart valve
Artificial joints
Blood thinners
Defibrillator
Rapid heartbeat with epinephrine
Premedication prior to procedures
History of poorly differentiated Squamous Cell Carcinoma
Pregnancy or planning a pregnancy
Immunosuppression
Pain during intercourse
Urinary Incontinence
History of melanoma
Vaginal Dryness
Hepatitis
History of organ transplant
Referred from another dermatologist
History of Merkel Cell Carcinoma
History of MRSA
NONE OF THE ABOVE

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MEDICATIONS: (Please enter current medications; both prescribed and over the counter)

No Medications: ☐ **Medication List Attached:** ☐

No Changes Since Last Visit: ☐

Name:	Dose:	Frequency:

MEDICATION ALLERGIES: (Please enter all medication allergies)

No known Drug Allergies: ☐

Name:	Type of Reaction:

Pharmacy: _____ Phone:_____

Patient Signature Date

Patient Name (Printed)

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*****NOTICE*****
We are now required to have you answer the questions below.
Failure to complete this information will result in a delay of your appointment.
We apologize for any redundancies.

1. Alcohol Use (patients 18 years and older):
   - ☐ None
   - ☐ 1 drink or less per day
   - ☐ 1-2 drinks per day
   - ☐ 3 or more drinks per day

   How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? _____

2. Check the one that best fits (patients 12 years and older)
   - ☐ Never Smoked
   - ☐ Ex-smoker
   - ☐ Current Smoker (cigarettes, cigars or pipes)

3. Over the past 2 weeks, how often have you been bothered by any of the following problems.
   (0 = Not at all, 1 = Several Days, 2 = More than half the days, 3 = Nearly every day) (PHQ-2)

   (Patients 12 years and older)

	Circle the one that best fits.			
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

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4. Please answer the following (patients 18 years and older) Screening **# 8472**

Have you been tested for Hepatitis C? □ Yes or □ No

If no, would you like an order for the test sent to your lab or primary care physician? □ Yes or □ No

Do you have a history of Hepatitis C? □ Yes or □ No
Were you born between 1945 – 1965? □ Yes or □ No
Do you have a history of blood transfusions prior to 1992? □ Yes or □ No
Are you receiving maintenance hemodialysis? □ Yes or □ No
Do you have a history of injection drug use? (recreational or prescribed) □ Yes or □ No
Are you a current intravenous drug user? (recreational or prescribed) □ Yes or □ No

Patient Name (Printed) Relationship to patient Date

Signature