COLORADO SPRINGS DERMATOLOGY CLINIC

Patient Name: _____ **DOB:** _____

Primary Care Doctor:_____**If you were referred here, provide doctor's name**:_____

Preferred Language: _____**Race:** _____**Marital Status**_____

Ethnic Group: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ I choose not to specify

Pharmacy name_____**address**_____**phone**_____

Past Medical History: (please check all that apply)

☐ Anxiety	☐ Depression	☐ Hyperthyroidism
☐ Arthritis	☐ Diabetes	☐ Hypothyroidism
☐ Asthma	☐ End stage renal disease	☐ Leukemia
☐ Atrial fibrillation	☐ GERD	☐ Lung cancer
☐ Bone marrow transplant	☐ Head trauma	☐ Lymphoma
☐ BPH	☐ Hearing loss	☐ Prostate cancer
☐ Breast cancer	☐ Hepatitis	☐ Radiation treatment
☐ Colon cancer	☐ Hypertension	☐ Seizures
☐ COPD	☐ HIV / AIDS	☐ Stroke
☐ Coronary artery disease	☐ Hypercholesterolemia	

Other:

Past Surgical History: (please check all that apply)

☐ Appendix removed	☐ Kidney biopsy
☐ Bladder removed	☐ Kidney removed (right, left)
☐ Breast Biopsy (right, left, bilateral)	☐ Kidney stone removal
☐ Lumpectomy (right, left, bilateral)	☐ Kidney transplant
☐ Mastectomy (right, left, bilateral)	☐ Kidney removed
☐ Colectomy	☐ Hepatectomy
☐ Colostomy	☐ Liver transplant
☐ Gallbladder removed	☐ Liver shunt
☐ Coronary artery bypass	☐ Ovaries removed: (endometriosis, cancer, cyst)
☐ Angioplasty (PTCA)	☐ Pancreas removed
☐ Biological valve replacement	☐ Prostate removed: (cancer, TURP)
☐ Mechanical valve replacement	☐ Rectal resection
☐ Heart transplant	☐ Spleen removed
☐ Hip replacement (right, left, bilateral)	☐ Testicles removed (right, left, bilateral)
☐ Knee replacement (right, left, bilateral)	☐ Hysterectomy (fibroids, uterine cancer, cervical cancer)

Other:

Skin Disease History: (please check all that apply)

☐ Acne	☐ Dry skin	☐ Poison Ivy
☐ Actinic keratosis	☐ Eczema	☐ Precancerous moles
☐ Asthma	☐ Flaking/itchy scalp	☐ Psoriasis
☐ Basal cell skin cancer	☐ Hay fever/allergies	☐ Squamous cell skin cancer
☐ Blistering sunburns	☐ Melanoma	

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 MALIGNANT MELANOMA?

☐YES ☐NO

If yes, which relative(s): _____

MEDICATIONS (please list all current medications including the dose and frequency):

_____ _____

_____ _____

_____ _____

_____ _____

☐NO MEDICATIONS

DRUG ALLERGIES (please list all known allergies and reactions):

_____ _____

_____ _____

☐NO KNOWN DRUG ALLERGIES

SOCIAL HISTORY:

Smoking status: ☐Current every day smoker ☐Current someday smoker
Date you started smoking _____ Date you quit smoking_____
☐ Former smoker ☐ Never smoker

I understand smoking can cause wrinkles and slow wound healing.

Alcohol use: ☐None ☐< 1 drink per day ☐1-2 drinks per day ☐3 or more drinks per day

Male patient: How many times in the past year have you had 5 or more drinks in a day?_____

Female patient: How many times in the past year have you had 5 or more drinks in a day?_____

Occupation: _____

ALERTS: (please circle all that apply)		
Allergy to adhesive	Artificial joint replacement	MRSA
Allergy to latex	Blood thinners	Pacemaker
Allergy to lidocaine	Defibrillator	Require antibiotics prior to procedure
Artificial valve replacement	Keloid scarring	Rapid heart beat with epinephrine

ARE YOU PREGNANT OR CURRENTLY TRYING TO GET PREGNANT? ☐YES ☐NO

HAVE YOU HAD A FLU SHOT THIS SEASON? ☐ YES ☐ NO DATE RECEIVED:_____

HAVE YOU EVER HAD A PNEUMONIA SHOT? ☐ YES ☐ NO

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (Please check yes or no)

Symptom	Yes	No
Are you in generally good health?		
Do you have problems with bleeding?		
Do you have problems with healing?		
Do you have problems with scarring?		
Do you currently have a rash?		
Do you have any new skin lesions?		
Do you have any changing skin lesions?		

Patient signature:_____