Medical History Form

Patient Name: ________________________________ **Date:** _____________ **MRN:** ________________

Referring Physician: ____

- **PATIENT DEMOGRAPHICS**

Date of Birth: ________________ **Gender:** ◯Male ◯Female **Preferred Language:**_______________

Race (Please check one):
◯ White
◯ American Indian or Alaska Native
◯ Asian
◯ Black or African American
◯ Native Hawaiian or Other Pacific Islander
◯ Other Race

Ethnic Group (Please check one):
◯ Hispanic or Latino
◯ Not Hispanic or Latino

- **PAST MEDICAL HISTORY (Please check all that apply):**

◯ **NONE**
◯ Anxiety
◯ Arthritis
◯ Asthma
◯ Atrial Fibrillation
◯ BPH (Enlarged Prostate)
◯ Bone Marrow Transplantation
◯ Breast Cancer
◯ Colon Cancer
◯ COPD (Chronic Lung Disease)
◯ Coronary Artery Disease
◯ Depression
◯ Diabetes
◯ End Stage Renal Disease
◯ GERD (acid reflux)
◯ Hearing Loss
◯ Hepatitis
◯ Hypertension
◯ HIV/AIDS
◯ Hypercholesterolemia
◯ Hyperthyroidism
◯ Hypothyroidism
◯ Leukemia
◯ Lung Cancer
◯ Lymphoma
◯ Prostate Cancer
◯ Radiation Treatment
◯ Seizures
◯ Stroke
◯ Other: ____

- **PAST SURGICAL HISTORY (Please check all that apply):**

◯ **NONE**
◯ Appendix Removed
◯ Bladder Removed
◯ Mastectomy ◯Right ◯Left
◯ Lumpectomy ◯Right ◯Left
◯ Breast Biopsy
◯ Breast Reduction
◯ Breast Implants
◯ Colectomy: Colon Cancer
◯ Colectomy: Diverticulitis
◯ Colectomy: IBD
◯ Gallbladder Removed
◯ Coronary Artery Bypass
◯ PTCA (Angioplasty)
◯ Mechanical Valve Replacement
◯ Biological Valve Replacement
◯ Heart Transplant
◯ Hip Replacement ◯Right ◯Left
◯ Knee Replacement ◯Right ◯Left
◯ Kidney Biopsy
◯ Kidney Removed ◯Right ◯Left
◯ Kidney Stone Removal
◯ Kidney Transplant
◯ Ovaries Removed: Endometriosis
◯ Ovaries Removed: Cyst
◯ Ovaries Removed: Ovarian Cancer
◯ Prostate Removed: Prostate Cancer
◯ Prostate Biopsy
◯ TURP (Prostate Surgery)
◯ Skin Biopsy
◯ Basal Cell Cancer Surgery
◯ Squamous Cell Cancer Surgery
◯ Melanoma Surgery
◯ Spleen Removed
◯ Testicles Removed ◯Right ◯Left
◯ Hysterectomy: Fibroids
◯ Hysterectomy: Uterine Cancer
◯ Other: ____

- **SKIN DISEASE HISTORY (Please check all that apply):** ◯ **NONE**

◯ Acne
◯ Actinic Keratoses
◯ Asthma
◯ Basal Cell Skin Cancer
◯ Blistering Sunburns
◯ Dry Skin
◯ Eczema
◯ Flaky or Itchy Scalp
◯ Hay Fever/Allergies
◯ Melanoma
◯ Poison Ivy
◯ Precancerous Moles
◯ Psoriasis
◯ Squamous Cell Skin Cancer

- **FAMILY HISTORY OF SKIN CANCER (Please check all that apply):** **NONE**

Basal Cell/Squamous Carcinoma Melanoma

Which Relative: ____

- **MEDICATIONS:** ◯ **NONE**

____

____

- **ALLERGIES:** ◯ **NONE**

____

____

- **SOCIAL HISTORY (Please check all that apply):**

Alcohol Use:
◯ **NONE**
◯ Less than 1 drink a day
◯ 1-2 drinks a day
◯ 3 or more drinks a day

Cigarette Smoking:
◯ Never Smoked
◯ Quit: Former Smoker
◯ Smokes less than daily
◯ Smokes daily

- **REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (Please check all that apply)**

◯ **NONE**
◯ Allergy to Adhesive
◯ Blood Thinners
◯ Pregnancy or Planning a Pregnancy
◯ Swollen Lymph Nodes
◯ Problems with Bleeding
◯ Problems with Healing
◯ Problems with Scarring (hypertrophic/keloid)
◯ Rash
◯ Immunosuppression
◯ Hay Fever
◯ Chest Pain
◯ Fever or Chills
◯ Night Sweats
◯ Unintentional Weight Loss
◯ Thyroid Problems
◯ Sore Throat
◯ Blurry Vision
◯ Abdominal Pain
◯ Bloody Stool
◯ Arthritis
◯ Muscle Weakness
◯ Neck Stiffness
◯ Headaches
◯ Seizures
◯ Cough
◯ Shortness of Breath
◯ Asthma
◯ Anxiety
◯ Depression
◯ Other: ____

- **ALERTS:** ◯ **NONE**

◯ Allergy to Lidocaine
◯ Allergy to topical Antibiotic OIntment
◯ Artificial Heart Valve
Defibrillator
◯ Pacemaker
◯ Premedication with antibiotics prior to procedure
◯ Rapid Heartbeat with Epinephrine
◯ Other: ____

Cosmetic Intake Form

****Please complete this questionnaire if you have any cosmetic concerns or interest in any of the cosmetic services that we offer at Derrow Dermatology****

Name: ____________________________ **Email:** __________________________________

By supplying my email address above, I give permission to Derrow Dermatology Associates LLC to contact me via email.

Would you like us to contact you if we are running any sales/promotions?

****<u>Do you have any of the following:</u>**

- Wrinkles on your face?
    - Forehead/Brow
    - Crows Feet
    - Cheeks
    - Around the mouth
        - Are you interested in Botox?
        - Are you interested in Fillers?
        - Are you interested in laser resurfacing?
        - Are you interested in medicated creams/cosmeceuticals?
- Unwanted Hair?
    - Are you interested in laser hair removal?
    - Are you interested in electrolysis?
- Brown spots on your skin?
    - Are you interested in light treatment (IPL)?
    - Are you interested in medicated creams (retinoids/hydroquinone)?
    - Are you interested in chemical peels?
- Red spots/dilated blood vessels/rosacea?
    - Are you interested in light treatment (IPL)?
    - Are you interested in medicated creams/cosmeceuticals?
- Spider Veins on your legs?
    - Are you interested in sclerotherapy?
- Loss of eyelashes?
    - Are you interested in Latisse?
- General skin care questions?
    - Are you interested in facials/extractions?
    - Are you interested in skin care products?