RIVERCHASE DERMATOLOGY
AND COSMETIC SURGERY

Patient Name:_____ Date:_____ DOB:_____

Past Medical History: (please circle all that apply)

Anxiety	Depression	Hyperthyroid
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial fibrillation	GERD	Lymphoma
Bone Marrow Transplant	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Breast Cancer	Hypertension	Seizures
Colon Cancer	HIV/AIDS	Stroke
COPD	High Cholesterol	
Coronary Artery Disease	Hypothyroid	**NONE**

Other: _____

Past Surgical History: (please circle all that apply)

Appendix Removed: (Appendectomy)	Liver: Hepatectomy
Bladder Removed (Cystectomy)	Liver: Liver Transplant
Mastectomy (Right, Left, Bilateral)	Liver: Shunt
Lumpectomy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Ovarian Cancer
Colon/Colectomy: Colon Cancer Resection	Ovaries Removed: Cyst
Colon/Colectomy: Diverticulitis	Ovaries: Tubal Ligation
Colectomy: IBD	Pancreas: Pancreatectomy
Colectomy: Colostomy	Prostate: Biopsy
Gallbladder Removed: (Cholecystectomy)	Prostate: Cancer
Heart: Biological Valve Replacement	Prostate: TURP (Prostate Removal)
Heart: CABG (Bypass)	Rectum: APR
Heart: Transplant	Rectum: Low Anterior Resection
Heart: Mechanical Valve Replacement	Skin: Basal Cell Carcinoma
Heart: PTCA (Angioplasty)	Skin: Melanoma
Joint Replacement, Knee: (Right, Left, Bilateral)	Skin: Skin Biopsy
	Skin: Squamous Cell Carcinoma
Joint Replacement, Hip: (Right, Left, Bilateral)	Spleen
	Testicles Removed (Right, Left, Bilateral)
Kidney: Biopsy	Uterus: (Hysterectomy) Fibroids
Kidney Stone Removal	Uterus: (Hysterectomy) Uterine Cancer
Kidney Transplant	Uterus: (Hysterectomy) Cervical Cancer
Kidney: Nephrectomy (Right, Left)	**None**

Other: _____

_____

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Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Skin Cancer
Blistering Sunburns	Melanoma	**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)? _____

Medications: (Please enter all current medications & dosage)

_____
_____
_____

Allergies: (Please enter all drug allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Never smoked
Currently Smokes
Has smoked in the past
Former Smoker

Alcohol Use:

EtOH- NONE
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Family History: Significant disease & illness, skin or otherwise. Only first degree biological relatives- Mother, Father, Brother, Sister and Children)

CONDITION	RELATIVE

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Review of Systems: Are you currently experiencing any of the following? (Please check "YES" or "NO")

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Abdominal Pain			**Muscle Weakness**		
Anxiety			**Neck Stiffness**		
Bloody Stool			**Night Sweats**		
Bloody Urine			**Problems with bleeding**		
Blurred Vision			**Problems with healing**		
Chest Pain			**Scarring (Hypertrophic/Keloids)**		
Depression			**Seizures**		
Fever or Chills			**Shortness of breath**		
Hay Fever			**Thyroid problems**		
Headaches			**Unintentional weight loss**		
Immunosuppression			**Wheezing**		
Joint Aches			**Other:**		

Alerts: (please check all that apply)

- □ Allergy to Adhesive
- □ Blood Thinners
- □ Defibrillator
- □ Hepatitis B/C
- □ History of Melanoma
- □ HIV/AIDS
- □ Iodine Allergy
- □ Lactating/Breastfeeding
- □ Latex Allergy
- □ Lidocaine Allergy
- □ Medication Allergy- PLEASE MAKE SURE ALL ALLERGIES ARE LISTING ON PREVIOUS SHEET
- □ Pacemaker
- □ Polysporin Allergy
- □ Pregnant or Planning Pregnancy
- □ Preoperative Antibiotics

Preferred pharmacy Name: _____

Location (cross roads):_____

Phone#: _____

Fax#:_____

City or Zip code:_____