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

Other: _____

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 list all current medications & dosages)
_____
_____
_____

Allergies: (Please list all drug allergies)
_____
_____
_____

Social History:

Cigarette Smoking:	**Alcohol Use:**
Never Smoked	None
Currently Smokes	Less than 1 drink per day
Has smoked in the past	1-2 drinks per day
Former Smoker	3 or more drinks per day

Family History: (Significant diseases & illness, skin or otherwise. Only first-degree biological relatives- mother, father, brother, sister and children)

CONDITION **RELATIVE**

_____
_____
_____
_____
_____
_____

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 LISTED ON THE PREVIOUS SHEET
□ Pacemaker
□ Polysporin Allergy
□ Pregnant or Planning Pregnancy
□ Preoperative Antibiotics

Pharmacy:

Pharmacy Name: _____
Location (crossroads): _____
Phone: _____
Fax: _____
City or Zip Code: _____