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 disorder	☐Disease caused by 2019-nCoV	☐Hypothyroidism
☐ Arthritis	☐ Elevated Blood Pressure	☐ Inflammatory disease of the liver
☐ Asthma	☐ End Stage Renal Disease	☐ Leukemia
☐ Atrial Fibrillation	☐ Epilepsy	☐ Malignant Lymphoma
☐ Benign Prosthetic Hyperplasia	☐ GERD	☐ Malignant tumor of breast
☐ Cerebrovascular Accident	☐ H/O Hypertension	☐ Malignant tumor of colon
☐ COPD	☐ Hearing loss	☐ Malignant tumor of prostate
☐ Coronary Arteriosclerosis	☐ HIV/AIDS	☐ Radiation treatment
☐ Depressive disorder	☐ Hypercholesterolemia	☐ Transplantation of bone marrow
☐ Diabetes Mellitus	☐ Hyperthyroidism	

Other:

Past Surgical History: (please check all that apply)

☐ Abdominoperineal Resection	☐Hysterectomy
☐ Bilateral replacement of knee joints	☐ Kidney biopsy
☐ Biopsy of breast (left, right, bilateral)	☐ Low anterior resection of rectum
☐ Biopsy of Prostate	☐ Lumpectomy of breast (left, right, bilateral)
☐ Coronary Artery bypass graft	☐ Mastectomy of breast (left, right)
☐ Entire transplanted kidney	☐ Mechanical Valve replacement
☐ Excision of Basal Cell Carcinoma	☐ Oophorectomy
☐ Excision of Melanoma	☐ Pancreatectomy
☐ Excision of Squamous Cell Carcinoma	☐ Percutaneous extraction of kidney stones-fragmentation
☐ H/O Colostomy	☐ Portosystemic shunt operation
☐ H/O Tubal Ligation	☐ Prostatectomy
☐ History of Appendectomy	☐ Prosthetic arthroplasty of bilateral hips
☐ History of Bilateral Mastectomy	☐ Splenectomy
☐ History of Cholecystectomy	☐ Surgical biopsy of the skin
☐ History of Colectomy	☐ Total Nephrectomy
☐ History of liver excision	☐ Total Orchidectomy
☐ History of PTCA	☐ Total replacement of Hip (left, right, bilateral)
☐ History of tissue graft heart valve replacement	☐ Total replacement of knee joint (left, right)
☐ History of total cystectomy	☐ Transplantation of heart
☐ History of transurethral prostatectomy	☐Transplantation of liver

Other:

Skin Disease History: (please check all that apply)

☐Acne	☐Dysplastic nevus of skin	☐Pruritus of scalp
☐ Actinic Keratosis	☐ Eczema	☐ Psoriasis
☐ Asteatosis Cutis	☐ H/O Asthma	☐ Squamous Cell Carcinoma
☐ Basal Cell Carcinoma	☐ H/O hay fever	☐ Sunburn of second degree
☐ Contact Dermatitis due to poison Ivy	☐ Malignant Melanoma	☐

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): _____

HEIGHT: _____**WEIGHT:** _____

DO YOU HAVE A HEALTH CARE PROXY IN THE EVENT YOU ARE UNABLE TO MAKE YOUR OWN MEDICAL DECISIONS? ☐ YES ☐ NO

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 smoker ☐ Current occasional smoker
Date you started smoking _____Date you quit smoking _____
☐ Former smoker ☐ Never smoker

Alcohol use: ☐ None ☐ < 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day
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 ☐Allergy to latex ☐Allergy to lidocaine ☐Artificial valve replacement	☐Artificial joint replacement ☐Blood thinners ☐Defibrillator ☐Keloid scarring	☐MRSA ☐Pacemaker ☐Require antibiotics prior to procedure ☐Rapid heartbeat with epinephrine

ARE YOU CURRENTLY PREGNANT? ☐ YES ☐ NO If yes how many weeks? _____

ARE YOU 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?		