Avail DERMATOLOGY

Patient Name: _____ Patient DOB: ___/___/___ Patient ID: _____

Preferred Pharmacy Information:

Name: _____ Phone Number: _____ City or Zip Code: _____

Past Medical History:

Select any of the following medical conditions you currently have or have been diagnosed with:

☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Atrial Fibrillation ☐ Bone Marrow Transplant ☐ BPH (Enlarged prostate) ☐ Breast Cancer ☐ Colon Cancer ☐ COPD (Emphysema) ☐ Coronary Artery Disease ☐ Depression ☐ Diabetes	☐ Kidney Failure ☐ GERD (Reflux / Heartburn) ☐ Hearing Loss ☐ Hepatitis ☐ High Blood Pressure ☐ HIV / AIDS ☐ High Cholesterol ☐ Thyroid Disease ☐ Leukemia ☐ Lung cancer ☐ Lymphoma ☐ Prostate Cancer	☐ Radiation Treatment ☐ Seizures ☐ Stroke ☐ NONE ☐ Other: _____ _____ _____ _____ _____

Past Surgical History:

Have you ever had any of the following surgeries?

☐ Appendix (Appendectomy) ☐ Breast: Breast Biopsy ☐ Breast: Lumpectomy (Right, Left, Bilateral) ☐ Breast: Mastectomy (Right, Left, Bilateral) ☐ Colon (Colectomy) ☐ Gallbladder (Cholecystectomy) ☐ Heart: Coronary Artery Bypass Surgery ☐ Heart: Valve Replacement ☐ Heart: Stent ☐ Joint Replacement: Hip (Right, Left, Bilateral) ☐ Joint Replacement: Knee (Right, Left, Bilateral) ☐ Kidney: Kidney Biopsy ☐ Kidney: Kidney Stone Removal ☐ Kidney: Kidney Transplant	☐ Ovaries: Endometriosis ☐ Ovaries: Ovarian Cancer ☐ Ovaries: Ovarian Cyst ☐ Prostate: Prostate Biopsy ☐ Prostate: Prostate Cancer ☐ Prostate: TURP ☐ Skin: Basal Cell Carcinoma ☐ Skin: Melanoma ☐ Skin: Skin Biopsy ☐ Skin: Squamous Cell Carcinoma ☐ Testicles (Orchiectomy) ☐ Uterus: Fibroids ☐ Uterus: Uterine/Cervical Cancer ☐ NONE ☐ Other: _____ _____

Have you had any of the following skin conditions?

☐ Acne ☐ Actinic Keratoses ☐ Asthma ☐ Basal Cell Skin Cancer ☐ Blistering Sunburns ☐ Dry Skin ☐ Eczema ☐ Flaking or Itchy Scalp ☐ Hay Fever / Allergies ☐ Melanoma	☐ Poison Ivy ☐ Precancerous Moles ☐ Psoriasis ☐ Squamous Cell Skin Cancer ☐ NONE ☐ Other: _____ _____ _____ _____

Skin Disease History:

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? _____

Medication list:

List all current medications:

Name of medication	Dosage	Frequency	Route of administration

Allergies:
List all allergies and reactions if known:

_____
_____
_____
_____

Social History MIPS

Smoking Status (Please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:
- mm/dd/yyyy _____

Quit Smoking:
- mm/dd/yyyy _____

Number of packs per day: _____
Total years smoking: _____

Alcohol Intake (Please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

How many times in the past year have you had 5 or more drinks in a day for men, 4 or more drinks in a day for women? _____
_____
_____
_____

Influenza:

Have you had your flu shot this year?
- ☐ Yes
- ☐ NO

If no, why? _____

Pneumonia:

Have you ever had the pneumonia vaccine? (If you are 65 or over)
- ☐ Yes
- ☐ No

If no, why? _____

Advance Care:

Do you have an advance care plan or surrogate decision maker?
- ☐ Yes
- ☐ No

If yes, contact name and number: _____
_____
_____
_____
_____
_____

Family Health history:
Please include only first-degree relatives:

_____

_____

_____

_____

Review of Systems:

Please Check yes or no for the following:

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		

Alerts

Please check yes or no for the following:

Symptom	Yes	No
Allergy to adhesive		
Allergy to lidocaine		
Allergy to topical antibiotic ointments		
Artificial heart valve		
Artificial joints within past two years		
Blood thinners (currently taking)		
Defibrillator		
MRSA (Staph infection)		
Pacemaker		
Premedication prior to procedure		
Rapid heartbeat with epinephrine		
Pregnancy or planning a pregnancy		

Notes: