REVELUS Dermatology

PATIENT MEDICAL HISTORY INTAKE

Board-Certified Dermatologists

PAST MEDICAL HISTORY

Check any medical conditions that you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH
- ☐ Blood clot
- ☐ Cerebrovascular accident
- ☐ Obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depression
- ☐ Diabetes
- ☐ Elevated Blood Pressure
- ☐ End Stage Renal Disease
- ☐ Epilepsy
- ☐ Gastroesophageal reflux disease
- ☐ Gout
- ☐ Hypertension
- ☐ Hearing Loss
- ☐ Viral Hepatitis
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Liver Disease
- ☐ Kidney Stone
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Liver Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Kidney Cancer
- ☐ Lung Cancer
- ☐ Ovary Cancer
- ☐ Prostate Cancer
- ☐ Thyroid Cancer
- ☐ Prostate Cancer
- ☐ Bone Marrow Transplant
- ☐ **None**

If other, what conditions?

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List any surgeries that you have ever had:

- ☐ Coronary artery bypass graft
- ☐ Excision of Basal Cell
- ☐ Excision of Melanoma
- ☐ Excision of Squamous Cell
- ☐ Artificial Heart Valve
- ☐ Tubal Ligation
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Heart Valve Replacement
- ☐ Cystectomy
- ☐ Hysterectomy
- ☐ Pacemaker
- ☐ Lumpectomy: Left breast
- ☐ Mastectomy: Left Breast
- ☐ Mastectomy: Right Breast
- ☐ Oophorectomy
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Nephrectomy
- ☐ Organ Transplant
- ☐
- ☐ **None**

If other, what surgeries?

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SKIN DISEASE HISTORY

Check any skin conditions that you have ever had:

- ☐ Acne
- ☐ Actinic keratoses
- ☐ Asteatosis cutis
- ☐ Basal cell skin cancer
- ☐ Dysplastic nevus
- ☐ Eczema
- ☐ Asthma
- ☐ Herpes zoster (shingles)
- ☐ Herpes Simplex
- ☐ Keloid
- ☐ Melanoma
- ☐ Lymphoma of the skin
- ☐ Partial loss of hair
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Squamous cell carcinoma
- ☐ Sunburn of second degree
- ☐ **None**

If other, what skin diseases?

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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, who? ______________________________

MEDICATIONS

Are you taking any medications? ☐ Yes ☐ No

If yes, what medications? If you have a list, please provide it.

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DRUG ALLERGIES

Do you have drug allergies or reactions? ☐ Yes ☐ No

If yes, what medications? If you have a list, please provide it.

____

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ADVANCE CARE PLANNING (Quality Measure)

Do you have a healthcare Proxy? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

Not selecting an answer will be an assumption of "No"

SOCIAL HISTORY

Check your Smoking Status (any nicotine):

☐ Everyday ☐ Some days ☐ Former Smoker ☐ Never

Check all Social History Details that Currently Apply:

- ☐ Not sexually active
- ☐ 1 Sexual Partner
- ☐ Multiple Sexual Partners
- ☐ Same Sex Partner
- ☐ Drug Use
- ☐ No Alcohol Consumption
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day
- ☐ IV Drug use

FAMILY HISTORY

Check any conditions that run in your family.

First degree relatives only (mother, brother, sister etc.)

- ☐ Arthritis Who? ______________
- ☐ Asthma Who? ______________
- ☐ Psoriasis Who? ______________
- ☐ Cancer Who? ______________
- ☐ Skin Cancer Who? ______________

If yes, what type of skin cancer? ______________

If there is additional family history, what conditions and family which family members?

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CONTACT INFORMATION

OK to leave a Detailed Voicemail? ☐ Yes ☐ No

PHARMACY

Provide the name and intersection or address:

If you don't have a pharmacy or want to support local businesses, we suggest Victory Medical across from Target

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PRACTICE INFORMATION

Do you have a primary care physician? ☐ Yes ☐ No

If yes, who is the physician?

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Were you referred by a Physician? ☐ Yes ☐ No

If yes, who was the physician, PA, or nurse?

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REVIEW OF SYSTEMS

Check any situations that apply:

- ☐ Changing Moles/Lesions
- ☐ Itchiness
- ☐ Rash
- ☐ Extreme Fatigue
- ☐ Unintentional Weight Loss
- ☐ Problems with Bleeding
- ☐ Swollen Glands/Lymph Nodes
- ☐ Numbness/Tingling
- ☐ Cough
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Frequent Urination
- ☐ Muscle Weakness
- ☐ Allergy to Adhesive
- ☐ Allergy to Topical Antibiotic
- ☐ Pacemaker/Defibrillator
- ☐ Bone Marrow Transplant
- ☐ Blood Thinner /Daily Aspirin
- ☐ Immunosuppression
- ☐ MRSA (Resistant Staph)
- ☐ Accutane in the 6 months
- ☐ Artificial Joint in the last 2 years
- ☐ Hair Loss
- ☐ Problems with Scarring
- ☐ Blood Clots
- ☐ Fever/Chills
- ☐ Night Sweats
- ☐ Headaches
- ☐ Insomnia
- ☐ Excessive Thirst
- ☐ Shortness of Breath
- ☐ Bloody Stool
- ☐ Difficulty Swallowing
- ☐ Joint Aches
- ☐ Chest Pain
- ☐ Allergy to Lidocaine
- ☐ Artificial Heart Valve
- ☐ Pregnant or Planning
- ☐ Stomach Ulcers
- ☐ Organ Transplant
- ☐ Hepatitis B or C
- ☐ HIV/AIDS

SIGNATURE

I understand that my signature below confirms that the information on this form is accurate and complete to the best of knowledge.

______________________________	______________________________	______________	______________
Patient, Guardian, or Responsible Individual Signature	Patient Name	Patient DOB	Date Signed