Patient Name: _____

Date of Birth:_____

Premier Dermatology & Cosmetic Surgery

Information Sheet

Pharmacy: _____ Phone: _____

Family Physician:_____ Phone: _____

Cardiologist: _____ Phone: _____

Ophthalmologist: _____ Phone:_____

Dermatologist: _____ Phone: _____

Past Medical History:

(Check all that apply)

- ☐ Adrenal Insufficiency
- ☐ Anemia/Thalassemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrilation (irregular Heartbeat)
- ☐ Auto- Immune Disease
- ☐ Bipolar Disorder
- ☐ Blood Clotting Disorder
- ☐ BPH
- ☐ Breast Cancer
- ☐ **Cold Sores**
- ☐ Colon Cancer
- ☐ **Congestive Heart Failure**
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes
- ☐ Easy Bruising
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ **Glaucoma**
- ☐ Head Trauma
- ☐ Hearing Loss
- ☐ **Heart Attack**
- ☐ **Heart Murmur**
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ **Injury to Nose**
- ☐ **Keloids/Unusual Scarring**
- ☐ **Leukemia**
- ☐ **Liver Disease**
- ☐ Lung Cancer
- ☐ **Lung Disease**
- ☐ Lupus
- ☐ Lymphoma
- ☐ Malignant Hypertension
- ☐ Mental Health Hospitalization
- ☐ **Mitral Valve Prolapse**
- ☐ Neuromuscular Disorder
- ☐ **Pacemaker**
- ☐ Paralysis
- ☐ Pneumothorax
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Radiation Treatment
- ☐ Renal Disorder
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Severe Reaction to Anesthesia
- ☐ **Shingles**
- ☐ **Sinus Conditions**
- ☐ **Sleep Apnea**
- ☐ **Spinal/Back Disorder**
- ☐ **Stomach Problem/Ulcer**
- ☐ Stroke
- ☐ Trauma
- ☐ Valvular Heart Disease
- ☐ Vision Loss
- ☐ Other _____

Past Surgeries:

(Check all that apply)

Abdomen:
- ☐ Laparoscopy
- ☐ Laparotomy

Abdominal Wall:
- ☐ Hernia Repair- Left Femoral
- ☐ Hernia Repair- Left Inguinal
- ☐ Hernia Repair- Right Femoral
- ☐ Hernia Repair- Right Inguinal
- ☐ Hernia Repair- Umbilical
- ☐ Hernia Repair- Ventral
- ☐ **Appendix** (Appendectomy)
- ☐ **Bladder** (Cystectomy)

Brain:
- ☐ Surgery for Cancer
- ☐ Surgery for Trauma

Breast:
- ☐ Breast Biopsy
- ☐ Lumpectomy- Both breasts
- ☐ Lumpectomy- Left breast
- ☐ Lumpectomy- Right breast
- ☐ Mastectomy- Both breasts
- ☐ Mastectomy- Left Breast
- ☐ Mastectomy- Right Breast
- ☐ **Cesarean Section**

Colon:
- ☐ Colon Cancer Resection
- ☐ Diverticulitis
- ☐ Inflammatory Bowel Disease
- ☐ Colostomy
- ☐ **Esophagus-** Esophagectomy
- ☐ **Gallbladder**

Heart:
- ☐ Biological Valve Replacement
- ☐ Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Mechanical Valve Replacement
- ☐ PTCA

Joint Replacement:
- ☐ Hip- Both
- ☐ Hip- Left
- ☐ Hip- Right
- ☐ Knee- Both
- ☐ Knee- Left
- ☐ Knee- Right

Kidney:
- ☐ Biopsy
- ☐ Stone Removal
- ☐ Transplant
- ☐ Nephrectomy

Liver:
- ☐ Hepatectomy
- ☐ Transplant
- ☐ Shunt

Lung:
- ☐ Left Lower Lobectomy
- ☐ Left Pneumonectomy
- ☐ Left Upper Lobectomy
- ☐ Right Lower Lobectomy
- ☐ Right Middle Lobectomy
- ☐ Right Pneumonectomy
- ☐ Right Upper Lobectomy

Ovaries:
- ☐ Endometriosis
- ☐ Ovarian Cancer
- ☐ Ovarian Cyst
- ☐ Tubal Ligation
- ☐ **Pancreas**- Pancreactomy

Prostate:
- ☐ Biopsy
- ☐ Cancer
- ☐ TURP

Rectum:
- ☐ APR
- ☐ Low Anterior Resection

Skin:
- ☐ Basal Cell Carcinoma
- ☐ Melanoma
- ☐ Skin Biopsy
- ☐ Squamous Cell Carcinoma
- ☐ **Small Bowel Resection**
- ☐ **Spine Surgery**
- ☐ **Spleen**- Splenectomy

Stomach:
- ☐ Gastrectomy
- ☐ Gastostomy
- ☐ **Testicles**- Orchiectomy

Uterus:
- ☐ Fibroids
- ☐ Uterine Cancer
- ☐ Cervical Cancer
- ☐ **Other** _____

Skin Disease:

(Check all that apply)

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Carcinoma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Other _____

Do you wear sunscreen? ○ Yes ○ No If Yes what SPF? _____
Do you tan in a tanning salon? ○ Yes ○ No

Plastic Surgery History:

(Check all that apply)

Abdomen:
- ☐ Abdominal Wall Reconstruction
- ☐ Abdominoplasty

Body Contouring:
- ☐ Brachioplasty
- ☐ Liposuction
- ☐ Lower Body Lift
- ☐ Thigh Lift
- ☐ Upper Body Lift

Breast:
- ☐ Augmentation
- ☐ Lift (Mastopexy)
- ☐ Reconstruction
- ☐ Reduction
- ☐ Correction of Nipple Inversion
- ☐ Implant Removal
- ☐ Nipple Reconstruction
- ☐ **Burn Wound Reconstruction**
- ☐ **Carpal Tunnel Release**
- ☐ **Chemical Peel**

Cleft:
- ☐ Lip Repair
- ☐ Palate Repair
- ☐ **Cubital Tunnel Release**
- ☐ **Decubitis Ulcer Reconstruction**

Ears:
- ☐ Reconstruction
- ☐ Earlobe Repair
- ☐ Otoplasty

Face:
- ☐ Blepharoplasty
- ☐ Brow Lift
- ☐ Cheek Augmentation
- ☐ Chin Augmentation
- ☐ Facelift
- ☐ Lefort Osteotomy
- ☐ Lower Blepharoplasty
- ☐ Orbital Floor Fracture
- ☐ Repair of Craniosynostosis
- ☐ Upper Blepharoplasty
- ☐ **Hair Restoration**
- ☐ **Laser Hair Removal**

Nose:
- ☐ Rhinoplasty
- ☐ Septoplasty
- ☐ **Scar Revision**
- ☐ **Other** _____
- ☐ **None**

Medications:

Please list all medications that you are taking and their dosage

Name:	

Allergies:

Please list all drug, anesthetic (numbing medication), tape, latex, iodine, or food allergy

Chief Complaint: Please briefly describe why you are here today and list any medication that you have tied for your complaint

_____

_____

Social History:

(Check all that apply)

Smoking Status: ○ Current ○ Former ○ Never
- □ Start Date: _____
- □ Quit Date: _____

Alcohol use: ○ None ○ less than 1 drink per day ○ 1-2 drinks per day ○ 3 or more per day
- □ Occupation_____

Family History:

(Check all that apply and write the family members relation)

- ☐ Non melanoma skin cancer _____
- ☐ Melanoma _____
- ☐ Asthma _____
- ☐ Breast Cancer _____
- ☐ Psoriasis _____
- ☐ Eczema _____
- ☐ Dermatitis _____
- ☐ Acne _____
- ☐ Malignant Hyperthermia_____
- ☐ Other _____

Review of Systems:

(Do you have any of the following problems or conditions? Check **Yes** or **No**)

Constitutional:

Fatigue	□Yes □No
Fever	□Yes □No
Weight loss or gain	□Yes □No
Night sweats	□Yes □No

HEENT:

Hearing Loss	□Yes □ No
Difficulty Breathing Through Nose	□Yes □No
Nose Bleeds	□Yes □No
Sinus Problems	□Yes □No
Blurred vision	□Yes □No
Double vision	□Yes □No
Dry Eyes	□Yes □No
Itching/Irritation of Eyes	□Yes □No
Dentures?	□Yes □No
Glasses?	□Yes □No

Respiratory:

Frequent Cough	□Yes □No
Shortness of Breath	□Yes □No
Wheezing	□Yes □No

Cardiovascular:

Chest Pain	□Yes □No
Leg Swelling	□Yes □No
Palpitations	□Yes □No

Gastrointestinal:

Abdominal pain	□Yes □No
Bowel habits change	□Yes □No
Indigestion/Heartburn	□Yes □No
Nausea/Vomiting	□Yes □No

Genitourinary:

Urinary frequency	□Yes □No
Painful Urination	□Yes □No
Nighttime Urination	□Yes □No

Integumentary:

Hair Loss	□Yes □No
Rashes	□Yes □No
Sores	□Yes □No

Neurological:

Dizzy Spells	□Yes □No
Numbness/Tingling	□Yes □No
Weakness/Paralysis	□Yes □No
Headaches	□Yes □No
Seizures	□Yes □No
Tremors	□Yes □No

Psychiatric:

Depression	□Yes □No
Mood Swings	□Yes □No
Recent Crisis	□Yes □No
Psychiatric Treatment	□Yes □No

Endocrine:

Cold Intolerance	□Yes □No
Heat Intolerance	□Yes □No
Excessive Thirst	□Yes □No
Excessive Sweating	□Yes □No

Musculoskeletal:

Back Pain	□Yes □No
Muscle Weakness	□Yes □No
Leg Pain	□Yes □No
Movement Limitation	□Yes □No

Hematologic/Lymphatic:

Easy Bruising	□Yes □No
Spontaneous Bleeding	□Yes □No
Blood Clotting	□Yes □No

Allergic/Immunologic:

Environmental Allergies	□Yes □No

Cautions:

(Check all that apply)

- □ Allergy to adhesive
- □ Allergy to latex
- □ Allergy to lidocaine
- □ Allergy to topical antibiotic ointments
- □ Artificial heart valve
- □ Artificial joints within past two years
- □ Blood thinners
- □ Defibrillator
- □ History of Melanoma
- □ Malignant hyperthermia
- □ MRSA
- □ Pacemaker
- □ Premedication prior to procedures
- □ Rapid heartbeat with epinephrine
- □ Pregnancy or planning pregnancy

Signature:_____

Date:_____