ASPEN DERMATOLOGY

Medical History

Review of Systems (please check all that apply to your health condition)			
Problems with bleeding		Neck stiffness	
Problems with healing		Headaches	
Problems with scarring (hypertrophic or keloid)		Seizures	
Rash		Numbness/tingling	
Fever or chills		Depression	
Night sweats		Photosensitivity	
Unintentional weight loss		Accutane use	
Blurry vision		Immunosuppression/biologic use	
Sore throat		Immunosuppressive/organ transplant	
Difficulty swallowing		Immunosuppressive/other	
Oral sores		Allergy to adhesive	
Cough		Allergy to lidocaine	
Shortness of breath		Allergy to topical antibiotic ointments	
Wheezing		Artificial heart valve	
Palpitations		Artificial joints within past two years	
Chest pain		Blood thinners	
Valvular heart disease		Defibrillator	
History of heart attack/stroke		MRSA	
Abdominal pain		Pacemaker	
Bloody stool		Premedication prior to procedures	
Diarrhea		Rapid heartbeat with epinephrine	
Constipation		Latex allergy	
Bloody urine		International travel or contact	
Burning on urination			
Joint aches			
Muscle weakness			

Alerts

Have you ever had difficulty stopping bleeding? YES NO	Do you have a pacemaker? YES NO
Do you require antibiotics prior to a surgical procedure? Y N	Do you have a defibrillator? YES NO
Have you had an artificial joint replacement? YES NO	Are you pregnant or currently trying to get pregnant? Y N
Do you have an artificial heart valve? YES NO	

FOR PATIENTS 65 AND OLDER

Have you received a pneumonia vaccine? YES NO

Advanced care planning

Do you have a health care proxy in the event you are unable to make your own medical decisions? YES NO

Designee's name:_________________________________ Designee's phone number:__________________________

Do you have a living will? YES NO

Which statement best reflects your wishes on advanced care recommendations?

- Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life
- Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.
- Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Medical History

Patient: ____Date of Birth: ____/____/____ Today's Date:___/____/_____

Reason for today's visit:____

Past Medical History (please check all that apply)

Anxiety disorder		Elevated blood pressure		Leukemia	
Arthritis		End-stage renal disease		Malignant lymphoma	
Asthma		Epilepsy		Malignant tumor of lung	
Atrial fibrillation		GERD-Gastro Esophageal reflux disease		Malignant tumor of breast	
BPH-Benign prostatic hyperplasia		H/O: Hypertension		Malignant tumor of colon	
Cerebrovascular accident		Hearing loss		Malignant tumor of prostate	
COPD		HIV		Radiation therapy treatment management	
Coronary arteriosclerosis		Hypercholesterolemia		Transplantation of bone marrow	
Depressive disorder		Hyperthyroidism		Other (please list):	
Diabetes mellitus		Hypothyroidism			
Disease caused by 2019-nCov		Inflammatory disease of liver			

Past Surgical History (please check all that apply)

Abdominoperineal resection		Lumpectomy of breast	
Bilateral replacement of knee joints		Lumpectomy of left breast	
Biopsy of breast		Lumpectomy of right breast	
Biopsy of prostate		Mastectomy of left breast	
Coronary artery bypass graft		Mastectomy of right breast	
Entire transplanted kidney		Mechanical heart valve replacement	
Excision of basal cell carcinoma		Oophorectomy	
Excision of melanoma		Pancreatectomy	
Excision of squamous cell carcinoma		Percutaneous extraction of kidney stone with fragmentation procedure	
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 skin	
History of colectomy		Total nephrectomy	
History of liver excision		Total orchidectomy	
History of percutaneous transluminal coronary angioplasty		Total replacement of left hip joint	
History of tissue graft heart valve replacement		Total replacement of left knee joint	
History of total cystectomy		Total replacement of the right hip joint	
History of transurethral prostatectomy		Total replacement of the right knee joint	
Hysterectomy		Transplantation of heart	
Kidney biopsy		Transplantation of liver	
Low anterior resection of rectum		Other (please list):	

Medical History

Skin Disease History (Please check all that apply)

None		Dysplastic nevus of skin		Psoriasis	
Acne		Eczema		Squamous cell carcinoma	
Actinic Keratosis		H/O: Asthma		Sunburn of second degree	
Asteatosis cutis		H/O: Hay fever		Other (please list):	
Basal cell carcinoma of skin		Malignant Melanoma			
Contact dermatitis due to poison ivy		Pruritis of scalp			

Skin Protection			
Do you wear Sunscreen? YES NO		**Do you tan in a tanning salon?** YES NO	
If YES, what SPF?			
Family History of Melanoma			
Do you have a family history of melanoma? YES NO			
If YES, check all that apply:			
Mother		Aunt	
Father		Nephew	
Sister		Niece	
Brother		Grandfather	
Daughter		Grandmother	
Son		Grandson	
Uncle		Granddaughter	

Medications (prescriptions, over-the-counter meds, vitamins and herbals)	
1.	5.
2.	6.
3.	7.
4.	8.

Medication Allergies Check here if none ☐	
1.	4.
2.	5.
3.	6.

## Social History		## Alcohol and Drug Use	
What is your smoking status?		How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women, or any for adults over 65?	
Unspecified		**Do you consume alcohol (EtOH or grain alcohol)?**	
Unknown if ever smoked		EtOH none	
Current everyday smoker		EtOH less than 1 drink per day	
Current some day smoker (tobacco)		EtOH 1-2 drinks per day	
Current some day smoker (cigarette)		EtOH 3 or more drinks per day	
Former smoker		**Illicit drug use?** YES NO	
Never smoker			
Smoker, current status unknown		**Vaccinations**	
Cigar smoker		Are your vaccinations current? YES NO	
Heavy tobacco smoker		For patients ages 65 or older, have you had a pneumonia vaccination? YES NO	
Light tobacco smoker			