deschutes dermatology
MEDICAL AESTHETIC

Name: _____DOB: _____Today's Date: _____New Patient? Y / N

1.) Pharmacy (please include city): _____

2.) Past Medical History: (please circle all that apply)

Anxiety	COPD (emphysema)	High Blood Pressure	Prostate Cancer
Arthritis	Coronary Artery Disease	HIV/AIDS	Radiation Treatment
Asthma	Depression	High Cholesterol	Seizures
Atrial Fibrillation	Diabetes	Low thyroid	Stroke
BPH (enlarged prostate)	End Stage Kidney Disease	High thyroid	Other: _____
Bone Marrow Transplant	GERD (heart burn)	Leukemia	
Breast Cancer	Hearing Loss	Lung Cancer	*NONE*
Colon Cancer	Hepatitis	Lymphoma	

3.) Past Surgeries: _____

For patients 65 and older:

Have you had your pneumonia vaccine? YES / NO

Do you have an advanced directive? YES / NO Who is listed as your health care proxy? _____

4.) Skin Disease History: (please circle all that apply)

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

Do you wear Sunscreen? YES / NO What SPF? _____ Do you tan in a tanning salon? YES / NO

5.) Family History

Do you have a <u>family</u> history of Melanoma? YES / NO Which Relative? _____

6.) Medications PLEASE PRINT (including prescription, over the counter, vitamins, herbals, etc.):

_____

7.) Medication allergies PLEASE PRINT (and reaction to that medication): _____

8.) Social History (please circle all that apply)

	Never smoked		No alcohol consumption	**OCCUPATION**:
SMOKING	Former smoker		Less than 1 drink per day	
TOBACCO	Current some-days smoker	**ALCOHOL**	1-2 drinks per day	_____
	Current every-day smoker		3 or more drinks per day	

9.) Review of Systems (please circle all that apply)

Feeling unwell	Problems with bleeding	Abdominal pain	Anxiety
Fever or chills	Problems with healing	Joint aches	Depression
Night sweats	Problems with scarring	Muscle Weakness	
Unintentional weight loss	Immunosuppression	Headaches	*NONE*
Cough	Thyroid problems	Seizures	

10.) Alerts (please circle all that apply)

Allergy to adhesive	Blood thinners	Pregnancy or planning pregnancy
Allergy to lidocaine	Defibrillator	Rapid heartbeat with epinephrine
Allergy to topical antibiotic ointments	MRSA (Staph infection)	
Artificial heart valve	Pacemaker	*NONE*
Artificial joints within past two years	Premedication prior to procedures	