Date: ___/___/___

Rocky Mountain DERMATOLOGY

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Boulder, CO 80302
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Name: _____ Occupation: _____ Prefer to be Called: _____ Current Age: _____

Height: _____ Weight: _____ DOB: ___/___/_____

General Medical History: Do you have or have you ever had any of the following?

Y	N	ANXIETY	Y	N	DEPRESSION	Y	N	LEUKEMIA
Y	N	ARTHRITIS	Y	N	DIABETES	Y	N	LUNG CANCER
Y	N	ARTIFICIAL JOINTS	Y	N	END STAGE RENAL DISEASE	Y	N	LUPUS
Y	N	ASTHMA	Y	N	GERD	Y	N	LYMPHOMA
Y	N	ATRIAL FIBRILLATION	Y	N	HEARING LOSS	Y	N	MIGRAINES
Y	N	BPH	Y	N	HEPATITIS	Y	N	PACEMAKER
Y	N	BONE MARROW TRANSPLANT	Y	N	HYPERTENSION	Y	N	PROSTATE CANCER
Y	N	BREAST CANCER	Y	N	HIV/ AIDS	Y	N	RADIATION TREATMENT
Y	N	COLON CANCER	Y	N	HYPERCHOLESTEROLEMIA	Y	N	SEIZURES
Y	N	COPD	Y	N	HYPERTHYROIDISM	Y	N	STROKE
Y	N	CORONARY ARTERY DISEASE	Y	N	HYPOTHYROIDISM	Y	N	VALVE REPLACEMENT

NONE / OTHER: _____

Surgeries:

Y	N	APPENDIX REMOVED	Y	N	BIOLOGICAL VALVE REPLACEMENT	Y	N	OVARIES REMOVED: Ovarian Cancer
Y	N	BLADDER REMOVED	Y	N	HEART TRANSPLANT	Y	N	PROSTATE REMOVED: Prostate Cancer
Y	N	MASTECTOMY (right, left, bilateral)	Y	N	JOINT REPLACEMENT, KNEE	Y	N	PROSTATE BIOPSY
Y	N	LUMPECTOMY (right, left, bilateral)			(right, left, bilateral)	Y	N	TURP
Y	N	BREAST BIOPSY (right, left, bilateral)	Y	N	JOINT REPLACEMENT, HIP	Y	N	SKIN BIOPSY
Y	N	BREAST REDUCTION			(right, left, bilateral)	Y	N	BASAL CELL CANCER SURGERY
Y	N	BREAST IMPLANTS	Y	N	JOINT REPLACEMENT WITHIN 2 YEARS	Y	N	SQUAMOUS CELL CARCINOMA SURGERY
Y	N	COLECTOMY: Colon Cancer Resection	Y	N	KIDNEY BIOPSY	Y	N	MELANOMA SURGERY
Y	N	COLECTOMY: Diverticulitis	Y	N	KIDNEY REMOVED	Y	N	SPLEEN REMOVED
Y	N	COLECTOMY: IBD	Y	N	KIDNEY STONE REMOVED	Y	N	TESTICLES REMOVED (right, left, bilateral)
Y	N	GALLBLADDER REMOVED	Y	N	KIDNEY TRANSPLANT	Y	N	HYSTERECTOMY: Fibroids
Y	N	CORONARY ARTERY BYPASS	Y	N	OVARIES REMOVED: Endometriosis	Y	N	HYSTERECTOMY: Uterine Cancer
Y	N	PTCA	Y	N	OVARIES REMOVED: Cyst			
Y	N	MECHANICAL VALVE REPLACEMENT						

NONE / OTHER _____

Skin Type: If 1st exposed to the sun in the summer without sunscreen, would you: ☐ 1. always burn, never tan ☐ 2. Always burn, sometimes tan ☐ 3. sometimes burn, always tan gradually ☐ 4. Burn minimally, always tan well ☐ 5. Rarely burn, tan profusely ☐ 6. Never burn, deeply pigmented

Skin History: Do you have or have you ever had any of the following?

Y	N	ACNE	Y	N	DRY SKIN	Y	N	MELANOMA
Y	N	ACTINIC KERATOSES	Y	N	ECZEMA	Y	N	POISON IVY
Y	N	BASAL CELL SKIN CANCER	Y	N	FLAKING OR ITCHY SCALP	Y	N	PRECANCEROUS MOLES
Y	N	BLISTERING SUNBURNS	Y	N	HAY FEVER /ALLERGIES	Y	N	PSORIASIS
						Y	N	SQUAMOUS CELL SKIN CANCER

NONE / OTHER _____

Do you wear sunscreen? Y OR N If yes, what SPF? _____ Do you tan in a tanning salon? Y OR N

Family History: Circle any conditions affecting a blood relative. Specify who is affected below, then circle.

Melanoma Basal cell or squamous cell skin cancer Psoriasis Eczema Hayfever or allergies Asthma Acne

Do you have a family history of melanoma? Y OR N

If yes, which relative(s)? _____

Any other family history?: _____

Y	N	Are you pregnant or breastfeeding?	If not, method of birth control: _____			Y	N	Are you contemplating pregnancy?
Y	N	Tubal ligation (tubes tied)	Y	N	Hysterectomy (if yes, uterus only or uterus and ovaries?)	Y	N	Yeast infections when taking antibiotics

Other Medical Problems or Surgeries: _____

_____

Social History: (Please check all that apply)

Sexual History:
- ☐ Not sexually active
- ☐ Active with one partner
- ☐ Sexually active with more than one partner
- ☐ Sexually active with same gender partner

Illicit Drug Use:
- ☐ Drug Use
- ☐ IV Drug Use

Alcohol Use:
- ☐ None
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Safety:
- ☐ I feel safe at home
- ☐ I do not feel safe at home

Cigarette Smoking:
- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily

MEDICATION

Name	Dosage	How Often

ALLERGIES

Medication/Food	Reaction

SENSITIVITIES TO MEDICATION

Medication	Sensitivity