Bardstown Dermatology PSC

114 Manor Avenue Bardstown, Kentucky 40004 (502) 349-9999

me:		Date of Birth://_	
EASON FOR VISIT:			
eferred by:			
st Medical History: (please			
Anxiety	Heart Dise	ase	Hypothyroidism
Arthritis	Depression	n	Leukemia
Artificial joints	Diabetes		Lung Cancer
Asthma	Kidney Dis	sease	Lymphoma
Atrial fibrillation	Reflux		Pacemaker
BPH (Prostate Hyperplasia)	Hearing Loss		Prostate Cancer
Bone Marrow	Hepatitis		Radiation Treatmen
Transplantation	High Blood Pressure		Seizures
Breast Cancer	HIV/AIDS		Stroke
Colon Cancer	Hypercholesterolemia		Valve Replacement
COPD	Hyperthyroidism		
Other			
Appendix Removed Bladder Removed Mastectomy (Right, Left, B Lumpectomy (Right, Left, B Breast Biopsy (Right, Left, B Breast Reduction Breast Implants Colectomy: Colon Cancer F Colectomy: Diverticulitis Colectomy: BD Gallbladder Removed Coronary Artery Bypass PTCA Mechanical Valve Replacer Biological Valve Replacer Heart Transplant Joint Replacement, Knee (I Bilateral) Joint Replacement, Hip (Ri	Bilateral) Bilateral) Resection ment ent Right, Left,	Kidney Sto Kidney Tra Ovaries Re Ovaries Re Ovaries Re Prostate Bi TURP Skin Biopsy Basal Cell O Squamous Melanoma Spleen Ren Testicles R Bilateral) Hysterecto	noved (Right, Left) ne Removal ansplant moved: Endometriosis moved: Cyst moved: Ovarian Cancer emoved: Prostate Cance topsy y Cancer Surgery Cell Carcinoma Surgery Surgery
Bilateral) Joint Replacement within l Other	_	None	my. Oterme cancer

Completed by: Patient / Other

Reviewed by	7 :	DATE:

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Name:			Date of Birth:/
Skin Disease History: (pleas	e circle all that a	pply)	
Acne Actinic Keratoses (pre skin cancers) Asthma Basal Cell Skin Cancer Blistering Sunburns Other	Dry Skin Eczema Flaking or Itchy Hay Fever/Alle Melanoma Poison Ivy	•	Precancerous Moles Psoriasis Squamous Cell Skin Cancer None
Do you wear Sunscreen? Y If yes, what SPF? Do you tan in a tanning salon Do you have a family history	? Yes No		No
If yes, which relative(s)?			
Medications : (Please enter a	ll current medica	ations)	
Preferred Pharmacy:			
Allergies: (Please enter all al	lergies)		
Social History: (Please circle Currently Smokes - daily Currently Smokes - not daily Has smoked in the past Other		Has neve Drug Use None	r smoked
Completed by: Patient / Oth		ATE:	

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Name:	Date of Birth:	_/_	
Review of Systems: Are you currently experiencing any of the	ne following?		
(please mark if symptom is present)			

Symptom	Symptom
Latex allergy?	Thyroid problems?
Allergy to lidocaine?	Sore throat
Premedication prior to	Fever or chills?
procedures?	rever of chins.
Pacemaker / Defibrillator	Night sweats
Artificial Joint within last 2	Unintentional weight
years	loss?
Artificial heart valve?	Abdominal pain
Adhesive allergy?	Blurry vision
Allergy to topical antibiotic ointments?	Joint aches
Blood thinners?	Muscle weakness
Pregnancy or planning pregnancy?	Neck stiffness?
Rapid heart beat with	Headaches
epinephrine	0.1
Yeast infections with antibiotics?	Seizures
GI upset with antibiotics?	Anxiety
Problems with bleeding?	Depression
Problems with healing?	Cough
Problems with scarring	Shortness of breath
(hypertrophic / keloid)	
Changing mole	Bloody stool
Rash	Bloody urine
Immunosuppression	
Hay fever?	
Wheezing?	
OTHER:	

Completed by: Patient / Other			
Reviewed by:	DATE:		