DCM Skin Solutions

Muncie ● Carmel ● Marion

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PLEASE PRINT ALL INFORMATION

Name: _____Phone #: _____Date of Birth: _____

Address: _____City: _____Zip: _____

Email: _____ Referred by: _____

Family Physician: _____ **Preferred Pharmacy:** _____

Name of Guarantor: _____ Address of Guarantor: _____

Do you have a health care proxy in the event you are unable to make your own decisions?

YES / NO (circle one if 'yes' answer below)

Name: _____ Phone Number_____

Paperwork Completed By: _____ Relationship to Patient: _____

PLEASE MARK ALL THAT APPLY TO YOU:

RACE AND ETHNIC GROUP

- ○ White
- ○ American Indian / Alaskan Native
- ○ Asian
- ○ African American
- ○ Native Hawaiian / Pacific Islander
- ○ Hispanic or Latino
- ○ Other
- ○ _____

PAST MEDICAL HISTORY

- ○ Anxiety
- ○ Arthritis
- ○ Asthma
- ○ Atrial Fibrillation
- ○ Bone Marrow Transplant
- ○ BPH
- ○ Breast Caner
- ○ Colon Cancer
- ○ COPD
- ○ Coronary Artery Disease
- ○ Depression
- ○ Diabetes
- ○ End Stage Renal Disease
- ○ GERD
- ○ Hearing Loss
- ○ Hepatitis
- ○ Hypertension
- ○ HIV / AIDS
- ○ Hypercholesterolemia
- ○ Hyperthyroidism
- ○ Hypothyroidism
- ○ Leukemia
- ○ Lung Cancer
- ○ Lymphoma
- ○ Prostate Cancer
- ○ Radiation Treatment
- ○ Seizures
- ○ Stroke
- ○ Other_____
  _____
  _____
- ○ None

PAST SURGICAL HISTORY

- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast: Breast Biopsy
- Breast: Lumpectomy (Right, Left, Bilateral)
- Breast : Mastectomy (Right, Left, Bilateral)
- Colon: (Colectomy): Colon Cancer Resection
- Colon: (Colectomy): Diverticulitis
- Colon: Colostomy
- Gallbladder (Cholecystectomy)
- Heart: Coronary Arty Bypass Surgery
- Heart: Heart Transplant
- Heart: Mechanical Valve Replacement
- Heart: PTCA
- Joint Replacement: Hip (Right, Left, Bilateral)
- Joint Replacement: Knee (Right, Left, Bilateral)
- Kidney: Kidney Biopsy
- Kidney: Kidney Stone Removal
- Kidney: Kidney Transplant
- Kidney Nephrectomy
- Liver: Hepatectomy
- Liver: Liver Transplant
- Ovaries (Oophorectomy) : Endometriosis
- Ovaries (Oophorectomy): Ovarian Cancer
- Ovaries (Oophorectomy): Ovarian Cyst
- Ovaries: Tubal Ligation
- Pancreas: Pancreatectomy
- Prostate (Prostatectomy): Prostate Biopsy
- Prostate (Prostatectomy): Prostate Cancer
- Prostate (Prostatectomy): TURP
- Rectum : APR
- Rectum: Low Anterior Resection
- Skin: Basal Cell Carcinoma
- Skin: Melanoma
- Skin: Skin Biopsy
- Skin: Squamous Cell Carcinoma
- Spleen (Splenectomy)
- Testicles (Orchiectomy)
- Uterus (Hysterectomy) Fibroids
- Uterus (Hysterectomy): Uterine Cancer
- Uterus (Hysterectomy): Cervical Cancer
- Other_____
  _____

Skin Disease History

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- 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

Do you have a family history of Melanoma? ___Yes ___No If yes, which relative?

_____

Family History of your Immediate Family (Mom, Dad, Brother or Sister – the person can be deceased)

Example: Mother had a stroke.

_____

List all **PRESCRITION** medications you are **CURRENTLY** taking with the dosage (Require for all new patients)

_____	____MG	_____	___MG
_____	____MG	_____	___MG
_____	____MG	_____	___MG
_____	____MG	_____	___MG
_____	____MG	_____	___MG
_____	____MG	_____	___MG
_____	____MG	_____	___MG

List all Medication you are Allergic to:

_____

_____

Smoking Status (please choose one)

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Started Smoking _____

Quit Smoking _____
Number of Packs a day _____
Total years Smoking _____

Alcohol Intake (please choose one)

- None
- 1 or Less per day
- 1-2 per day
- 3 or more per day

Immunizations

- Pneumonia Vaccination
- Influenza Immunization

REVIEW OF SYSTEMS

- Problems with Bleeding
- Problems with Healing
- Unintentional Weight Loss
- Rash
- Problems with scarring (hypertrophic or keloid)
- Hay fever
- Night sweats
- Immunosuppression
- Chest pain
- Fever or chills
- Thyroid problems
- Sore throat
- Blurry vision
- Abdominal pain
- Bloody stool
- Bloody urine
- Joint aches
- Muscle weakness
- Neck stiffness
- Headaches
- Seizures
- Cough
- Shortness of breath
- Wheezing
- Anxiety
- Depression
- Hepatitis C
- HIV
- Defibrillator
- Pacemaker
- Blood Thinners
- Allergy to topical antibiotic ointments
- Allergy to lidocaine
- Allergy to adhesive
- Rapid Heartbeat with Epinephrine
- MRSA
- Premedication Prior to Procedures
- Pregnant or Planning a Pregnancy
- Artificial Heart Valve
- Artificial Joints in Past 2 years
- At risk for falls