dermatology associates OF LINCOLN

6969 South St | Lincoln, NE 68506 | 402-413-7460
Casey D Bowen, MD ● Gina L Weir, MD ● Jay Arthur, PA-C ● Christina Meyer, PA-C

PATIENT MEDICAL HISTORY

Patient Name:	Date of Birth:	Account #:
Preferred Pharmacy:	Pharmacy Location:	
Family Physician:	Referring Physician:	

PAST MEDICAL HISTORY

□ Anxiety
□ Arthritis
□ Asthma
□ Atrial fibrillation
□ Bone Marrow Transplant
□ BPH (benign prostatic hyperplasia)
□ Breast Cancer
□ Colon Cancer
□ COPD
□ Coronary Artery Disease
□ Depression
□ Diabetes
□ End Stage Renal Disease
□ GERD
□ Hearing Loss
□ Hepatitis A, B or C
□ High Blood Pressure
□ HIV/AIDS
□ High Cholesterol
□ Hyperthyroidism
□ Hypothyroidism
□ Leukemia
□ Lung Cancer
□ Lymphoma
□ Prostate Cancer
□ Radiation Treatment
□ Seizures
□ Stroke
□ Other_____
_____
_____
□ None

PAST SURGICAL HISTORY

□ Adenoids: Adenoidectomy
□ Appendix (appendectomy)
□ Bladder (cystectomy – surgical removal of bladder)
□ Breast: Biopsy
□ Breast: Lumpectomy (both)
□ Breast: Lumpectomy (left)
□ Breast: Lumpectomy (right)
□ Breast: Mastectomy (both)
□ Breast: Mastectomy (left)
□ Breast: Mastectomy (right)
□ Cesarean Section
□ Colon: (colectomy) Colon Cancer Resection
□ Colon: (colectomy) Diverticulitis
□ Colon: (colectomy) Inflammatory Bowel
□ Colon: Colostomy (surgical removal of colon)
□ Gallbladder (cholecystectomy)
□ Heart: Biological Valve Replacement
□ Heart: Coronary Artery Bypass
□ Heart: Heart Transplant
□ Heart: Mechanical Valve Replacement
□ Heart: PTCA (angioplasty)
□ Joint Replacement: Hip (both)
□ Joint Replacement: Hip (left)
□ Joint Replacement: Hip (right)
□ Joint Replacement: Knee (both)
□ Joint Replacement: Knee (left)
□ Joint Replacement: Knee (right)
□ Kidney: Biopsy
□ Kidney: Stone Removal
□ Kidney: Transplant
□ Kidney: Nephrectomy
□ Liver: Hepatectomy
□ Liver: Transplant
□ Liver: Shunt
□ Ovaries: (oophorectomy) Endometriosis
□ Ovaries: (oophorectomy) Ovarian Cancer
□ Ovaries: (oophorectomy) Ovarian Cyst
□ Ovaries: Tubal Ligation
□ Pancreas: Pancreatectomy
□ Prostate: Biopsy
□ Prostate: Cancer
□ Prostate: Transurethral Resection (TURP)
□ Rectum: Abdominal Perineal Resection (APR)
□ Rectum: Low Anterior Resection
□ Skin: Basal Cell Carcinoma
□ Skin: Melanoma
□ Skin: Biopsy
□ Skin: Squamous Cell Carcinoma
□ Spleen: Splenectomy
□ Testicles: Orchiectomy
□ Tonsils: Tonsillectomy
□ Uterus: (hysterectomy) Fibroids
□ Uterus: (hysterectomy) Uterine Cancer
□ Uterus: (hysterectomy) Cervical Cancer
□ Uterus: (hysterectomy) Other reason
□ Other_____
_____
□ None

Updated 12/16/2020

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Patient Name:_____ Date of Birth: _____ Account #: _____

SKIN DISEASE HISTORY

□ Acne
□ Actinic Keratosis (Pre-Skin Cancer)
□ Basal Cell Carcinoma
□ Blistering Sunburns
□ Dry Skin
□ Eczema
□ Flaking or Itchy Scalp
□ Melanoma
□ Poison Ivy
□ Precancerous Moles
□ Psoriasis
□ Squamous Cell Carcinoma
□ Other_____
_____
□ None

Do you wear sunscreen? □ Yes □ No If yes, what SPF? _____

Do you tan in a tanning salon? □ Yes □ No

Family history of melanoma? □ Yes □ No If yes, which relative? _____

MEDICATIONS

Do you provide consent for us to import your pharmacy records from Surescripts? □ Yes □ No
(Surescripts is used to electronically send prescriptions to a pharmacy.)

List all prescriptions, over-the-counter medications, herbals, and vitamin/mineral/dietary supplements:

Medication Name		Dosage	Frequency	Route

List drug allergies: _____

If yes, describe the reaction: _____
_____

SOCIAL HISTORY

Tobacco product use:
□ Never smoked
□ Former smoker - Date you quit: _____
□ Current every-day smoker
□ Current some day smoker (tobacco)
□ Current some-day smoker (cigarettes/vapor)
□ Cigar smoker

Alcohol use: □ None □ Less than 1 drink/day □ 1-2 drinks daily □ 3 or more drinks daily

Men: How many times in the past year did you have 5 or more drinks in a day? ___
Women: How many times in the past year did you have 4 or more drinks in a day? ___
Adults age 65+: How many times in the past year did you have 4 or more drinks in a day? ___

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Patient Name: _____ Date of Birth:_____ Account #: _____

QUALITY MEASURES

Have you received a Pneumonia vaccination? □ Yes □ No

Have you received your Flu Vaccination? □ Yes □ No □ Allergic □ Refused If yes, when? _____

Have you ever tested positive for TB? □ Yes □ No

REVIEW OF SYMPTOMS

Do you currently have a problem with any of the following? Please check all that apply.

Problems with bleeding?	□ Yes	□ No	Sore Throat	□ Yes	□ No
Problems with healing?	□ Yes	□ No	Thyroid Problems	□ Yes	□ No
Problems with scarring?	□ Yes	□ No	Unintentional Weight Loss	□ Yes	□ No
Abdominal Pain	□ Yes	□ No	Wheezing	□ Yes	□ No
Anxiety	□ Yes	□ No	Red Eye	□ Yes	□ No
Bloody Stool	□ Yes	□ No	Tearing	□ Yes	□ No
Bloody Urine	□ Yes	□ No	Eye Pain	□ Yes	□ No
Blurry Vision	□ Yes	□ No	Uncontrolled Blood Pressure	□ Yes	□ No
Chest Pain	□ Yes	□ No	Elevated Blood Sugar	□ Yes	□ No
Cough	□ Yes	□ No	Allergy to Adhesives	□ Yes	□ No
Depression	□ Yes	□ No	Allergy to Lidocaine	□ Yes	□ No
Dizziness	□ Yes	□ No	Allergy to topical antibiotic ointment	□ Yes	□ No
Fever/Chills	□ Yes	□ No	Artificial Heart Valves	□ Yes	□ No
Grey discoloration of skin	□ Yes	□ No	Artificial joints in the last 2 years	□ Yes	□ No
Hay Fever	□ Yes	□ No	Blood thinners	□ Yes	□ No
Headaches	□ Yes	□ No	Defibrillator	□ Yes	□ No
Immunosuppression	□ Yes	□ No	MRSA	□ Yes	□ No
Joint Aches	□ Yes	□ No	Pacemaker	□ Yes	□ No
If yes, for how long? _____			Currently pregnant	□ Yes	□ No
Night Sweats	□ Yes	□ No	Planning Pregnancy	□ Yes	□ No
Rashes/Hives	□ Yes	□ No	Currently Breastfeeding	□ Yes	□ No
Seizures	□ Yes	□ No	Premedication prior to procedure	□ Yes	□ No
Shortness of Breath	□ Yes	□ No	Rapid heartbeat w/epinephrine	□ Yes	□ No
Sleeplessness	□ Yes	□ No	Latex Allergy	□ Yes	□ No

_____ _____

Signature of Patient or Parent/Guardian **Date**

_____ _____

Parent/Guardian Name (Printed) **Relationship to Patient**

Updated 12/16/2020