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 ● Meredith McManaman, 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

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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? ___



Updated 7/14/2022

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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**