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:
Preferred Pharmacy:	Pharmacy Location:
Family Physician:	Referring Physician:

PAST MEDICAL HISTORY

□ None
□ Anxiety disorder
□ Arthritis
□ Asthma
□ Atrial fibrillation
□ Benign prostatic hyperplasia (BPH)
□ Cerebrovascular accident
□ Chronic obstructive lung disease
□ Coronary arteriosclerosis
□ Depressive disorder
□ Diabetes mellitus
□ Disease caused by 2019-nCoV (Covid-19)
□ Elevated blood pressure
□ End-stage renal disease
□ Epilepsy
□ Gastroesophageal reflux disease (GERD)
□ H/O: hypertension
□ Hearing loss
□ Human Immunodeficiency virus infection (HIV)
□ Hypercholesterolemia
□ Hyperthyroidism
□ Hypothyroidism
□ Inflammatory disease of liver
□ Leukemia
□ Malignant lymphoma
□ Malignant tumor of breast (Breast cancer)
□ Malignant tumor of colon (Colon cancer)
□ Malignant tumor of lung (Lung cancer)
□ Malignant tumor of prostate (prostate cancer)
□ Radiation therapy treatment management
□Transplantation of bone marrow
□ Other_____

PAST SURGICAL HISTORY

□ None
□ Abdominoperineal resection
□ Bilateral replacement of knee joints
□ Biopsy of breast
□ Biopsy of prostate
□ Coronary artery bypass graft
□ Entire transplanted kidney
□ Excision of basal cell carcinoma
□ Excision of melanoma
□ Excision of squamous cell carcinoma
□ H/O: cesarean section
□ H/O: colostomy
□ H/O: tubal ligation
□ History of adenoidectomy
□ History of appendectomy
□ History of bilateral mastectomy
□ History of cholecystectomy
□ History of colectomy
□ History of liver excision
□ History of percutaneous transluminal coronary angioplasty
□ History of tissue graft heart valve replacement
□ History of tonsillectomy
□ History of total cystectomy
□ History of transurethral prostatectomy
□ Hysterectomy
□ Kidney biopsy
□ Lower anterior resection of rectum
□ Lumpectomy of breast
□ Lumpectomy of left breast
□ Lumpectomy of right breast
□ Mastectomy of left breast
□ Mastectomy of right breast
□Mechanical heart valve replacement
□ Oophorectomy
□Pancreatectomy
□ Percutaneous extraction of kidney stone with fragmentation procedure
□ Portosystemic shunt operation
□ Prostatectomy
□ Prosthetic arthroplasty of bilateral hips
□ Splenectomy
□ Surgical biopsy of skin
□ Total nephrectomy
□ Total orchidectomy
□ Total replacement of left hip joint
□ Total replacement of left knee joint
□ Total replacement of right hip joint
□ Total replacement of right knee joint
□ Transplant of heart
□ Transplant of liver
□ Other: _____

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SKIN DISEASE HISTORY

□ None
□ Acne
□ Actinic Keratosis (Pre-Skin Cancer)
□ Asteatosis cutis
□ Basal Cell Carcinoma of skin
□ Contact dermatitis due to poison ivy
□ Dry skin
□ Dysplastic nevus of skin
□ Eczema
□ H/O: asthma
□ H/O: hay fever
□ Malignant melanoma
□ Pruritus of scalp
□ Psoriasis
□ Squamous Cell Carcinoma
□ Sunburn of second degree
□ Ultraviolet tanning device
□ Other_____

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: _____

QUALITY MEASURES

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.

Anxiety	□ Yes	□ No	Sleeplessness	□ Yes	□ No
Thyroid problems	□ Yes	□ No	Red eye	□ Yes	□ No
Blurry vision	□ Yes	□ No	Tearing	□ Yes	□ No
Headaches	□ Yes	□ No	Uncontrolled blood pressure	□ Yes	□ No
Hay fever	□ Yes	□ No	Uncontrolled blood sugar	□ Yes	□ No
Shortness of breath	□ Yes	□ No	Elevated Blood Sugar	□ Yes	□ No
Rash/Hives	□ Yes	□ No	HIV/AIDS	□ Yes	□ No
Bloody urine	□ Yes	□ No	Hepatitis B	□ Yes	□ No
Problems with healing	□ Yes	□ No	Hepatitis C	□ Yes	□ No
Night sweats	□ Yes	□ No	Have you ever tested positive for TB	□ Yes	□ No
Sore throat	□ Yes	□ No	Pacemaker	□ Yes	□ No
Depression	□ Yes	□ No	Defibrillator	□ Yes	□ No
Seizures	□ Yes	□ No	Planning a pregnancy	□ Yes	□ No
Chest pain	□ Yes	□ No	Artificial joints within past 2 years	□ Yes	□ No
Immunosuppression	□ Yes	□ No	Premedication prior to procedures	□ Yes	□ No
Abdominal pain	□ Yes	□ No	Allergy to topical antibiotic ointments	□ Yes	□ No
Unintentional weight loss	□ Yes	□ No	Allergy to adhesive	□ Yes	□ No
Wheezing	□ Yes	□ No	MRSA	□ Yes	□ No
Fever or chills	□ Yes	□ No	Blood thinners	□ Yes	□ No
Cough	□ Yes	□ No	Rapid heartbeat with epinephrine	□ Yes	□ No
Joint aches	□ Yes	□ No	Allergy to lidocaine	□ Yes	□ No
Problems with scarring	□ Yes	□ No	Artificial heart valve	□ Yes	□ No
Problems with bleeding	□ Yes	□ No	Currently pregnant	□ Yes	□ No
Bloody stool	□ Yes	□ No	Currently breastfeeding	□ Yes	□ No
Dizziness	□ Yes	□ No	Latex allergy	□ Yes	□ No
Grey discoloration of skin	□ Yes	□ No			

_____ _____

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

_____ _____

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