Palm Beach Dermatology: Dr Kelley

Name_____Date_____

Local
Address_____

Seasonal Address_____

SS#_____Date of Birth_____Age_____

Male/Female Race: Caucasian/African American/Asian/Native American/Hispanic
circle one circle one

Primary Telephone #_____

Email_____

Secondary Telephone #_____Preferred Language _____

Who referred you to our office?_____

Primary Care Physician_____ Phone #_____

Employment_____ Work phone#_____

Spouse_____ Spouse phone#_____

Emergency Contact_____ Phone#_____

Pharmacy name/location_____ Phone#_____

Have you had Mohs surgery before?_____What location?_____

History

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
Lung Cancer
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE
Other_____
_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other_____
_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

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(s)? _____

Medications: (Please enter all current medications)

_____
_____
_____
_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:
Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:
None
less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Family History (Only first degree relatives)

_____
_____
_____
_____

Review of Systems: Are you currently experiencing any of the following?
(Please circle all that apply)
Problem with Bleeding
Problems with Healing
Problems with Scarring
Rash
Immunosuppression
Chest Pain
Fever/Chills
Weight Loss
Cough
Shortness of Breath
Anxiety
Other Symptoms: _____

ALERTS: (please circle all that apply)
Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Are you pregnant or currently trying to get pregnant?