PALM BEACH DERMATOLOGY

Meylin Vega, PA-C

Patient Name_____Date of Bieth_____Date_____

Email Address_____Phone_____

Primary Care Physician_____Phone_____

Referred by_____Physician_____ ☐ Yes ☐ No

Primary (Default) Pharmacy Name_____Phone_____

Past Medical History

☐ Anxiety	☐ Arthritis	☐ Asthma	☐ Atrial Fibrillation
☐ Bone Marrow Transplant	☐ Enlarged Prostate	☐ Breast Cancer	☐ Colon Cancer
☐ COPD	☐ Coronary Artery Disease	☐ Depression	☐ Diabetes
☐ End Stage Renal Disease	☐ GERD	☐ Hearing Loss	☐ Hepatitis
☐ Underactive Thyroid	☐ Leukemia	☐ Prostate Cancer	☐ Seizures
☐ Radiation Treatment	☐ Stroke	☐ Hypertension	☐ Other_____

Past Surgical History

☐ Appendectomy	☐ Bladder Removed	☐ Colostomy	☐ Gallbladder Removal
☐ Pancreas Removed	☐ Spleen Removed	☐ Hysterectomy	☐ Ovaries Removed
☐ Coronary Artery Bypass Surgery	☐ Tubal Ligation	☐ Testicle Removed	☐ Colon Removed

Breast: ☐ Biopsy ☐ Lumpectomy ☐ Mastectomy ☐ Right ☐ Left ☐ Both

Heart: ☐ Valve Replacement ☐ Biological ☐ Mechanical ☐ Transplant ☐ Stent

Liver: ☐ Liver Removal ☐ Transplant ☐ Shunt

Knee Replacement: ☐ Right ☐ Left ☐ Both Hip Replacement: ☐ Right ☐ Left ☐Both

Kidney: ☐ Biopsy Cancer ☐ Tumor Rectum: APR ☐ Low Anterior Resection

Skin: ☐ Basal Cell Carcinoma ☐ Melanoma ☐ Skin Biopsy ☐ Squamous Cell Carcinoma

Other:_____

Skin Disease History

☐ Acne	☐ Actinic Keratosis (precancer)	☐ Asthma	☐ Basal Cell Carcinoma	☐ Blistering Sunburns
☐ Dry Skin	☐ Eczema ☐ Flaking/Itchy Scalp	☐ Hay fever	☐ Allergies	☐ Melanoma
☐ Poison Ivy	☐ Precancerous Moles	☐ Psoriasis	☐ Squamous Cell Carcinoma	

☐ Other_____

Do you wear sunscreen ☐ Yes ☐ No SPF_____ Do you use tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No Which relative?_____

Medications_____

_____

Allergies_____

Smoking status ☐ Never smoked ☐ Former smoker ☐ Sometimes ☐ Everyday Number of packs per day _____

Alcohol use ☐ None ☐ Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

How many times in the past year have you had 5 or more drinks in a day for men_____

How many times in the past year have you had 4 or more drinks in a day for women_____

□ Illicit Drug Use □ Drug use □ IV drug use

For patients 65 and older Have you received a pneumonia vaccination □ Yes □ No

Have you received a flu shot (January through March or October through December) □ Yes □ No

Do you have a health care proxy in the event you are unable to make your own medical decisions? □ Yes □ No

Designated Health Care Proxy name_____Phone_____

Do you have a Living Will □ Yes □ No

Family History

Please check if any blood relative has any condition(s) listed below

□ Allergies/Hay fever	Family Member_____	□ Childhood eczema	Family Member_____
□ Asthma	Family Member_____	□ Psoriasis	Family Member_____
□ Diabetes	Family Member_____	□ Skin cancer	Family Member_____
□ Other cancer	Family Member_____	□ Heart disease	Family Member_____
□ High blood pressure	Family Member_____	□ Autoimmune disease	Family Member_____
□ Other _____			Family Member_____

Review of systems

□ Problems with bleeding	□ Cough
□ Problems with healing	□ Shortness of breath
□ Problems with scarring (hypertrophic/keloid)	□ Wheezing
□ Rash	□ Anxiety
□ Immunosuppression	□ Depression
□Hay fever	□ Changing moles
□Chest pain	□ Allergy to adhesive
□ Fever or chills	□ Allergy to lidocaine
□ Night sweats	□ Allergy to topical antibiotic ointments
□ Unintentional weight loss	□ Artificial heart valve
□ Thyroid problems	□ Artificial joints within past two years
□ Sore throat	□ Blood thinners
□ Blurry vision	□ Defibrillator
□ Abdominal pain	□ MRSA
□ Bloody stool	□ Pacemaker
□ Bloody urine	□ Premedication prior to procedure
□ Joint aches	□ Rapid heartbeat with epinephrine
□ Muscle weakness	□ Pregnancy or planning pregnancy
□ Neck stiffness	□ West Africa: travel/contact
□ Headaches	□ HIV AIDS
□ Seizures	□ None