Valley Dermatology & Plastic Surgery

First Name:_____ **Last Name:**_____

Home Address (City/Zip Code):_____

Occupation:_____

Date of Birth:_____ **Social Security Number:**_____

Phone Number:_____ **Email:**_____

Can we leave a message with medical information? Yes No

Is there an emergency contact or someone we can speak with about your medical information with? Yes No If yes, please provide information below.

Name_____ **Phone**_____

Referring Physician (Name/Address/Phone/Fax): _____

_____

Primary Care Physician (Name/Address/Phone/Fax): _____

_____

Pharmacy (Name/Address/Phone/Fax):_____

_____

Current Medications (Including supplements and herbs):_____

_____

Allergies:_____

Medical History: (Circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
HIV/AIDS
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Diabetes
End Stage Renal Disease
GERD
Hay Fever/ Allergies
Heart Disease
Hepatitis
High Blood Pressure
High Cholesterol
Radiation Treatment
Leukemia/Lymphoma
Lung Cancer
Thyroid Disease
Prostate Cancer
Seizures
Stroke

Other:_____

Today's Date:_____

Past Surgical History: (Circle all that apply)

Appendix Removed
Tonsils Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Colectomy
Gallbladder removed
PTCA
Valve Replacement
Heart Transplant
Joint Replacement
-knee
-hip
-other:_____
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed
Pacemaker
Prostate Removed
TURP
Skin Biopsy
Basal Cell Carcinoma Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left)
Hysterectomy
Other:_____

Skin Disease History: (Circle all that apply)

Acne
Actinic Keratoses
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Rosacea
Squamous Cell Skin Cancer

Other:_____

Family History of Skin Cancer:

- Melanoma? Yes No If yes, who?_____
- Basal Cell Carcinoma? Yes No If yes, who?_____
- Squamous Cell Carcinoma? Yes No If yes, who?_____

Social History:

Smoking History? Yes No If yes, how many packs per day?

_____

Have you had the Flu Vaccine? Yes No
Have you had the Pneumococcal Vaccine? Yes No
Do you have an advance healthcare directive? Yes No

Have you ever had any cosmetic procedures done? Yes No
Would you like to hear about cosmetic options during your visit? Yes No
Would you like to receive emails on cosmetic specials and promotions? Yes No