RENAISSANCE
DERMATOLOGY & AESTHETICS

Patient Name: _____ Nickname: _____ DOB: _____

Primary Care Physician: _____ Referred By: _____

Pharmacy Name: _____ Pharmacy City/Zip code: _____

PAST MEDICAL HISTORY

Please check or list any health issue(s) that may be medically relevant.

☐ Anemia	☐ GERD (acid reflux)	☐ Kidney Disease	☐ Cancer:
☐ Arthritis	☐ Heart Disease	☐ Organ Transplant	
☐ Asthma	☐ Hepatitis	☐ Radiation Treatment	
☐ Autoimmune Disease	☐ High Blood Pressure	☐ Seizures	☐ Other:
☐ Chemotherapy	☐ High Cholesterol	☐ Stroke	
☐ Diabetes	☐ HIV/AIDS	☐ Thyroid Disease	

PAST SURGICAL HISTORY

*Please list any **recent** (i.e. within past 5 years) or **major** (i.e. artificial heart valve) surgical procedures.*

Month / Year *(Estimate)*	**Procedure**

SKIN HISTORY

Please check all that apply.

☐ Acne	☐ Dandruff	☐ Keloids	☐ Skin Cancer
☐ Actinic Keratosis	☐ Eczema	☐ Psoriasis	○ Basal Cell Carcinoma (BCC)
☐ Allergic Contact	☐ Fever Blisters	☐ Rosacea	○ Squamous Cell Carcinoma (SCC)
☐ Atypical Moles	☐ Hair Loss	☐ Shingles	○ Melanoma

Tanning bed use: ☐ Never ☐ Past ☐ Current

Family history of Melanoma: ☐ No ☐ Yes, my: ☐ Dad ☐ Mom ☐ Grandparent ☐ Sibling ☐ Child

MEDICATIONS

*Please list all **current** oral, topical, or injectable medications on the **back of this sheet.***

Include any vitamins, supplements, and over-the-counter products (i.e. Zyrtec) that you take daily.

If we have a copy of your pre-made medication list, you do NOT have to re-complete this section

MEDICATIONS

If we have a copy of your pre-made medication list, you do NOT have to re-complete this section

Name	Dose	Route	Frequency
(Example): Metformin	500 mg	oral	twice daily

Name: _____ DOB: _____ RMS #: _____

ALLERGIES TO MEDICATIONS

☐ No known drug allergies

Medication	**Reaction** (i.e. hives, rash, anaphylaxis)

MISCELLANEOUS

Have you ever had a reaction to numbing injections (i.e. lidocaine or epinephrine)?	☐ Yes	☐ No
Do you have an allergy to adhesives (i.e. Band-aids)?	☐ Yes	☐ No
Area you allergic to any antibiotic ointments (Ex: Neosporin, Bactroban)?	☐ Yes	☐ No
Have you ever had MR (i.e. staph infection)?	☐ Yes	☐ No
Are you on a daily aspirin or blood thinners (Ex: Plavix, Xarelto, Coumadin)?	☐ Yes	☐ No
Do you have an implantable device (defibrillator, pacemaker, insulin pump, cochlear)?	☐ Yes	☐ No
Do you have an artificial heart valve?	☐ Yes	☐ No
Have you had an artificial joint replacement in the past two years? ☐ Yes (site: _____)		☐ No
Do you require antibiotics prior to surgery?	☐ Yes	☐ No
Are you pregnant or currently trying to get pregnant?	☐ Yes	☐ No
Are you breastfeeding?	☐ Yes	☐ No

I understand the questions above and verify that all information is accurate.

Signature of Patient/Legal Guardian: _____ **Date:** _____