ORCHID
DERMATOLOGY

(PLEASE COMPLETE THIS FORM AND HAND IT TO A NURSE WHEN THEY BRING YOU BACK INTO A ROOM**)**

Patient Name:_____ **DOB:**_____ **Height:**_____ **Weight:**_____
Primary Care Physician:_____

Past Medical History: (please circle all that apply)

- None
- Anxiety disorder
- Arthritis
- Asthma
- Atrial Fibrillation
- Benign Prostatic Hyperplasia
- Cerebrovascular accident
- Chronic obstructive lung disease
- Coronary arteriosclerosis
- Depression
- Diabetes
- Disease cause by 2019-nCoV
- High blood pressure
- End-stage renal disease
- Epilepsy
- Acid Reflux
- Hearing loss
- HIV
- High Cholesterol
- Hyperthyroidism
- Hypothyroidism
- Inflammatory disease of liver
- Leukemia
- Malignant lymphoma
- Malignant tumour of lung
- Malignant tumour of breasts
- Malignant tumour of colon
- Malignant tumour prostate
- Radiation therapy treatment management
- Transplantation of bone marrow
- Other:_____
  _____
  _____

Past Surgical History: (please circle all that apply)

- None
- Abdominoperineal resection
- 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
- colostomy
- tubal ligation
- appendectomy
- cholecystectomy
- colostomy
- PTCA
- cystectomy
- Hysterectomy
- Kidney biopsy
- Lumpectomy of breast, Left/ Right/ Bilateral
- Mastectomy of left breast/Left/Right
- Mechanical heart valve replacement
- Oophorectomy
- Pancreatectomy
- Kidney stone removal
- Prostatectomy
- Splenectomy
- Surgical biopsy of skin
- Total nephrectomy
- Total orchiectomy
- Total replacement of left hip joint/Right Hip
- Total replacement of left knee joint/right knee
- Transplantation of heart
- Transplantation of liver

Other:_____
_____
_____

Skin Disease History: (please circle all that apply)

- None
- Acne
- Actinic Keratosis
- Basal cell carcinoma of skin
- Atopic dermatitis
- poison ivy
- Dysplastic nevus
- Eczema
- H/O: asthma
- H/O: hay fever
- Malignant melanoma
- Pruritus of scalp
- Psoriasis
- Squamous cell carcinoma
- Sunburn of second degree
- Lupus
- Shingles
- Cold Sores
- Vitiligo
- Other:_____
  _____
  _____
  _____
  _____

Skin Protection:

Do you wear sunscreen? _____ Yes _____ No
If yes, what SPF? _____
Do you tan in a tanning salon? _____ Yes _____ No

Family History of Melanoma:

Do you have a family history of melanoma? _____ Yes _____ No
If yes, which relative(s)?_____

Medications: (please enter all current medications & dosage)

Medication Name and Dose	**Frequency**

MedicationAllergies:_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking:

- Current everyday smoker
- Current some day smoker (tobacco)
- Current some day smoker (cigarette)
- Former smoker
- Never smoker
- Cigar Smoker
- Heavy tobacco smoker
- Light tobacco smoker
- NONE

Alcohol Use:

- less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day
- NONE

Have you had a pneumonia vaccine this year? _____ Yes ____ No
Have you had a flu vaccine this year? ____ Yes _____ No
If no, do you plan on getting one this year?_____

If over 65, do you have a medical proxy in the event that you cannot make your own medical decisions?
_____Yes _____No
If yes, what is their name and phone number?_____

Do you have a living will? _____

Do you have a Do Not Resuscitate or a Do Not Intubate?_____

Family History: Signification disease & illness, skin or otherwise. Only first degree biological relatives- Mother, Father, Brother, Sister, Children

Condition	**Relative**

Review of Systems: Are you currently experiencing any of the following?
(Please check "YES or "NO")

Symptom	Yes	No	Symptom	Yes	No
Abdominal Pain			Loss of smell or taste		
Muscle Weakness			Depression		
Anxiety			Seizures		
Neck Stiffness			Fever or Chills		
Bloody Stool			Shortness of Breath		
Bloody Urine			Hay Fever		
Problems with Bleeding			Thyroid Problems		
Blurred Vision			Headaches		
Problems with Healing			Unintentional Weight Loss		
Chest Pain			Immunosuppression		
Joint Aches			Wheezing		
Scarring (hypertrophic/keloid)			Other		

Alerts: (please circle all that apply)

- Blood Thinners
- Pacemaker
- Defibrillator
- Hepatitis B/C
- History of Melanoma
- HIV/AIDS
- Lactating or Breastfeeding
- Preoperative antibiotics
- Allergy to lidocaine
- EPI sensitive
- Pregnancy or planning pregnancy
- Latex Allergy
- Adhesive Allergy
- Joint replacements in last 6 months
- Vasovagal