DUNCAN DERMATOLOGY

1104 Adams St, Suite 201, St. Helena, CA 94574
Tel 707-967-0800 Fax 707-967-0870
www.DuncanDermatology.com

Patient Name: ____ **Date:** ____________________

Current Medical Conditions: (please circle all that apply)

Anxiety	Depression	Hypothyroidism
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial fibrillation	GERD	Lymphoma
Bone Marrow	Hearing Loss	Osteoporosis
Transplantation	Hepatitis	Prostate Cancer
Breast Cancer	High Blood pressure	Radiation Treatment
Colon Cancer	High Cholesterol	Seizures
COPD	HIV/AIDS	Stroke
Coronary Artery Disease	Hyperthyroidism	NONE

Other____

Past Surgeries: (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: Inflammatory Bowel Disease
Gallbladder Removed
Heart -Coronary Artery Bypass
Heart - Mechanical Valve Replacement
Heart - Biological Valve Replacement
Heart Transplant
Heart - PTCA
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Stone Removal
Kidney Transplant
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)

Liver
- Hepatectomy
- Transplant
- Shunt

Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Cyst
Ovaries – Tubal ligation
Prostate Removed: Prostate Cancer
Prostate Biopsy
Rectum
Skin
- Basal Cell Carcinoma
- Melanoma
- Skin biopsy
- Squamous Cell Carcinoma

Spleen Removed
Testicles Removed (Right, Left, Bilateral)
TURP (Prostate Removal)
Uterus
- Hysterectomy: Fibroids
- Hysterectomy: Uterine Cancer
- Hysterectomy: cervical Cancer

NONE

Other____

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Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy / Poison Oak
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever / Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	Rosacea
		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)? ____

List all medications you currently take, including over the counter medications:

Medication	Dose (mg)	How often (# / day)

Are you allergic to any medications? YES □ NO □

Medication	Describe allergic reaction

Social History: (Please circle all that apply)

Cigarette Smoking:

- Currently Smoke
- Never smoked
- Former Smoker

Alcohol Use:

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

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Patient Name: ____________________________ **Date:** ______________

Family History of Disease? (Immediate Family Members Only)

____

____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Accutane History (Complete Accutane ROS)		
Problems with bleeding		
Problems with healing		
Problems with scarring		
Rash		
Immunosuppression		
Hay fever		
Chest pain		
Night sweats		
Unintentional weight loss		
Cough		
Shortness of breath		
Fever or Chills		
Dry Skin		

Symptom	Yes	No
Headaches		
Blurry Vision		
Anxiety		
Depression		
Abdominal Pain		
Joint Aches		
Muscle Aches		
Fatigue		
Nausea/Vomiting/Diarrhea		
Swollen lymph nodes		
Pain/difficulty urinating		
Yellowing of the skin		
Thyroid Disorder		

Other Symptoms: ____

ALERTS: (please circle all that apply)

- Allergy to Adhesive
- Allergy to lidocaine
- Allergy to topical antibiotics
- Artificial heart valve
- Artificial joint replacement in past two years
- Blood thinners
- Defibrillator
- MRSA
- Pacemaker
- Require antibiotics prior to a surgical procedure
- Rapid heartbeat with epinephrine
- Are you pregnant or currently trying to get pregnant?
- West Africa travel or contact?

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Patient Name: ____ **Date:** _____________________

Preferred Language: _________________________

Race: _____________________ Ethnic Group: _______________________

Contact Information:

Emergency Contact Name: ___________________________________ Phone: ____________________

Spouse Name: ___________________________________ Phone: ____________________

Preferred Contact Phone Number (Circle number below the phone number to indicate the order of how you would like to receive calls.

Home: ______________________ Work: _____________________ Cell: ______________________
1 2 3 1 2 3 1 2 3

Is it okay to leave detailed information at contact number and/or email? YES NO

Primary Care MD: ____

Preferred pharmacy Name: ____ Phone#: ___________________

City or Zip code: ____