Palm Beach Dermatology
Oren Lifshitz, M.D.
10887 N. Military Trail, Suite 8
Palm Beach Gardens, FL 33410

Phone: 561-296-7546
Fax: 561-296-7545

Dermatology Medical History

Patient Name:_____ Age: _____

Reason for visit:_____

Medical History: Have you ever had the following diseases or conditions: (Please check YES or NO)

	Y	N		Y	N		Y	N
Anxiety	_	_	Diabetes	_	_	Liver disease	_	_
Arthritis	_	_	Hypertension	_	_	Leukemia	_	_
Asthma	_	_	End stage renal disease	_	_	Lymphoma	_	_
Atrial fibrillation	_	_	Seizures	_	_	Lung cancer	_	_
Benign prostatic hyperplasia	_	_	GERD	_	_	Breast cancer	_	_
Stroke	_	_	Hearing loss	_	_	Colon cancer	_	_
COPD	_	_	HIV/AIDS	_	_	Prostate cancer	_	_
Covid-19	_	_	High cholesterol	_	_	Radiation treatment	_	_
Coronary artery disease	_	_	Hyperthyroidism	_	_	Bone marrow transplant	_	_
Depression	_	_	Hypothyroidism	_	_	Other _____	_	_

Surgical History: Have you ever had any surgeries on the following organs: (Please check YES or NO)

	Y	N		Y	N		Y	N
None	_	_	Colectomy	_	_	Ovaries removed	_	_
Rectum resection	_	_	Liver excision	_	_	Pancreas removed	_	_
Biopsy of Breast	_	_	Angioplasty	_	_	Extraction of kidney stone	_	_
Biopsy of prostate	_	_	Heart valve replacement	_	_	Prostate removal	_	_
Coronary artery bypass graft	_	_	History of total cystectomy	_	_	Spleen Removed	_	_
Entire transplanted kidney	_	_	History of prostatectomy	_	_	Surgical biopsy of skin	_	_
Excision of basal cell carcinoma	_	_	Hysterectomy	_	_	Kidney removal	_	_
Excision of melanoma	_	_	Kidney biopsy	_	_	Testicle removed	_	_
Excision of squamous cell carcinoma	_	_	Lumpectomy of breast	_	_	Total replacement (L) hip joint	_	_
Colostomy	_	_	Lumpectomy of (L) breast	_	_	Replacement (L) Knee joint	_	_
Tubal ligation	_	_	Lumpectomy of (R) breast	_	_	Total replacement (R) hip joint	_	_
Appendix removed	_	_	Mastectomy of (L) breast	_	_	Replacement (R) knee joint	_	_
Bilateral mastectomy	_	_	Mastectomy of (R) breast	_	_	Transplantation of heart	_	_
Cholecystectomy	_	_	Heart valve replacement	_	_	Transplantation of liver	_	_

Other _____

Skin Disease: Have you ever had any of the following conditions: (Please check YES or NO)

	Y	N		Y	N		Y	N
Acne	_	_	Dysplastic nevus	_	_	Itchy scalp	_	_
Actinic keratosis	_	_	Eczema	_	_	Psoriasis	_	_
Asteatotic dermatitis	_	_	Asthma	_	_	Squamous cell carcinoma	_	_
Basal cell carcinoma	_	_	Hay fever	_	_	Blistering sunburn	_	_
Poison ivy	_	_	Melanoma	_	_	Other _____		

Skin History: (Please circle)

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)? _____

Medications: (Please list all current medications)

_____
_____
_____
_____

Allergies: (Please list all allergies)

_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:	Alcohol Use:	Sexual Activity:
Never smoked	None	Not sexually active
Quit: former smoker	Less than 1 drink per day	Sexually active with 1 partner
Smoker (packs/ day ___, total yrs___)	1-2 drinks per day	Sexually active with more than 1 partner
	3 or more drinks per day	

How many times in the past year you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____

Other:

How often do you exercise: _____
Describe your caffeine use: _____
Occupation (current or former, if retired): _____
Workplace: _____
Place of Residence: _____

Family History: Describe any family history (only first degree relatives)

_____
_____
_____

Race: (Circle all that apply)	Ethnicity: (Circle)	Preferred language
White	Hispanic/Latino	English
Black/African American	Non-Hispanic/Latino	Spanish

Asian

American Indian or Native American

Native Hawaiian/Pacific Islander

Other

Systems Review: Do you have any of the following issues: (Please check YES or NO)

	Y	N		Y	N		Y	N
Problems with bleeding	_	_	Unintentional weight loss	_	_	Neck stiffness	_	_
Problems with healing	_	_	Thyroid problems	_	_	Headaches	_	_
Problems with scarring	_	_	Sore throat	_	_	Seizures	_	_
Rash	_	_	Blurry vision	_	_	Cough	_	_
Immunosuppression	_	_	Abdominal pain	_	_	Shortness of breath	_	_
Hay fever	_	_	Bloody stool	_	_	Wheezing	_	_
Chest pain	_	_	Bloody urine	_	_	Anxiety	_	_
Fever or chills	_	_	Joint aches	_	_	Wheezing	_	_
Night sweats	_	_	Muscle weakness	_	_	Other _____		

Alerts: Do you have any of the following issues: (Please check YES or NO)

	Y	N		Y	N		Y	N
HIV Positive	_	_	Allergy: adhesive	_	_	MRSA	_	_
Hep C positive	_	_	Allergy: lidocaine	_	_	Pacemaker	_	_
Epi sensitivity	_	_	Allergy: topical antibiotic	_	_	Premed prior to procedure	_	_
Taking Plavix	_	_	Artificial heart valve	_	_	Rapid heartbeat with epi	_	_
Taking Coumadin	_	_	Artificial joint (past 2 yrs)	_	_	Pregnant or planning to become pregnant	_	_
Taking Aspirin	_	_	Blood thinners	_	_	West Africa travel	_	_
Taking Xarelto	_	_	Defibrillator	_	_	Risk of Ebola	_	_

Pharmacy:

Name: _____
Street address: _____
Zip Code: _____
Phone Number: _____

Do you consent to allowing our office to import your pharmacy prescriptions medications ❑ Yes ❑ No

Completed by: ❑ Patient Signature:_____ _____/_____/_____
Date

☐ Parent/Guardian Print Name: _____