PATIENT HISTORY –1:

Russel S. Glaun, M.D.
1590 N.W 10th Ave., Suite 304
Boca Raton, FL 33486

DOB: _____ **Name:** _____ **Date:** _____

PLEASE CIRCLE ALL THAT APPLY FOR ANY PAST OR PRESENT DISORDERS:

SKIN HISTORY: ***IF NONE CHECK THIS CIRCLE*** ◯

*Psoriasis–if systemic agent/biologic use–specify_____ *Dermatitis/eczema
*Blistering sunburns *Tanning salon use *Abnormal/dysplastic moles *Acne *Accutane–dates_____
*Allergy skin patch testing–date and results_____
*Photodynamic therapy/Blue light–most recent date and reason_____
*Melanoma–specify location, level or depth (if known), lymph node biopsy results (if done), imaging results (if done)_____
_____
*Basal cell carcinoma–specify locations_____
*Squamous cell carcinoma–specify locations _____
*Actinic keratosis/pre-cancer–specify prior treatments _____
*Other skin rashes/disorders/ Skin tumors - specify _____
_____

SYSTEMS HISTORY: ***IF NONE CHECK THIS CIRCLE*** ◯

*High blood pressure *Phlebitis/blood clots *Coronary artery disease *Asthma *Emphysema/COPD
*Tuberculosis *Arthritis *Lupus *Other rheumatologic–specify_____
*Colitis/Crohn's/IBD *Liver disease *Stomach ulcer *Gluten sensitivity *Thyroid disease
*Kidney disease *Dialysis *Seizures *Peripheral neuropathy *Diabetes
*Cancer–specify_____
*Chemotherapy–date last given _____
*Organ transplant–type, date _____
*Major injuries/surgeries–specify _____
*Other diseases–specify _____
_____

FAMILY HISTORY AND RELATIONSHIP: ***IF NONE CHECK THIS CIRCLE*** ◯

Melanoma_____ Dysplastic/abnormal moles_____ *Other skin cancer_____
* Psoriasis_____*Atopic dermatitis/asthma/hayfever _____ *Other skin_____

ALERTS/RISK FACTORS: ***CHECK IF NONE*** ◯

*Atrial fibrillation/arrhythmia * Herpes/fever blisters/cold sores *Unusual bruising/bleeding
*Blood thinners–specify_____ *Defibrillator
*Hepatitis B/hepatitis C *Staph infection *MRSA infection
*Exposed to HIV (AIDS) *Drug use *Latex allergy
*Oxygen use *Pacemaker *Allergy to lidocaine
*Rapid heartbeat with epinephrine *Antibiotics before surgical procedure *Heart valve replacement.
*Joint replacement *Scar/keloid easily *Faint/dizzy with procedures
*Allergy to adhesive–prefer paper tape *Poor wound healing *For females–currently pregnant/trying

TOBACCO HISTORY (SELECT ONE OPTION):

*Never a smoker
*Former smoker
*Current every day smoker
*Current some day smoker

ALCOHOL USE (SELECT ONE OPTION)

* Do not drink
* Drink alcohol socially
* For women and men over 65 - > 7 drinks per week or > 3 drinks per occasion.
* For men 65 or younger - > 14 drinks per week or > 4 drinks per occasion.

PATIENT HISTORY –2:

Russel S. Glaun, M.D.
1590 N.W 10th Ave., Suite 304
Boca Raton, FL 33486

DOB: __________ Name: ______________________________________ Date: __________

SKIN TOPICAL PRODUCTS (PRESCRIPTION & OTC)–name and reason why using: ***IF NONE CHECK THIS CIRCLE*** ◯

____

____

SKIN ORAL MEDICATIONS (PRESCRIPTION & OTC)–name and reason why taking: ***IF NONE CHECK THIS CIRCLE*** ◯

____

____

ALL OTHER MEDICATIONS (PRESCRIPTION & OTC) –name only: ***IF NONE CHECK THIS CIRCLE*** ◯

____

____

____

ALLERGIES TO MEDICATIONS: ***IF NONE CHECK THIS CIRCLE*** ◯

____

OTHER ALLERGIES OR ADVERSE REACTIONS: ***IF NONE CHECK THIS CIRCLE*** ◯

____

PRODUCT INFORMATION: Would you like information on:
*Blue light therapy for precancers or acne. *Skin care products *Botox *Juvederm filler

PHARMACY INFORMATION (for electronic prescribing)

Name: ____
Address or cross streets ____________________________________
City, State, Zip ____
Phone ____

Completed by: ◯ Patient
◯ Representative – Name ______________________ Relationship ______________

Signed ______________________________ Date ______________

∞∞∞

Reviewed by: Dr Russel Glaun ______________________________ Date ______________
EHR entry: ____ Date ______________

∞∞∞