vail | aspen | breckenridge | glenwood dermatology

PO Box 2736 / 1140 Edwards Village Blvd, B200, Edwards, CO 81632 | p. 970.926.9226 f. 970.926.8755

Patient Name: _____ Date of Birth: _____

Email: _____

Would you be interested in having your medications dispensed from Vail Aspen Breckenridge Glenwood Dermatology (for cash pay) through an FDA approved compounding facility if applicable to your appointment?

Yes / No

Past Medical History: (Circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Bone Marrow Transplantation
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other: _____

Past Surgical History: (Circle all that apply)

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast Biopsy
Breast: Lumpectomy (Both / Left / Right)
Breast: Mastectomy (Both / Left / Right)
Colon (Colectomy): Colon Cancer Resection
Colon (Colectomy): Diverticulitis
Colon (Colectomy): Inflammatory Bowel Disease
Colon: Colostomy
Gallbladder (Cholecystectomy)
Heart: Biological Valve Replacement
Heart: Coronary Artery Bypass Surgery
Heart: Heart Transplant
Heart: Mechanical Valve Replacement
Heart: PTCA
Joint Replacement: HIP (Both / Left / Right)
Joint Replacement: KNEE (Both / Left / Right)
Kidney Biopsy
Kidney: Kidney Stone Removal
Kidney: Kidney Transplant
Kidney: Nephrectomy
Liver: Hepatectomy
Liver: Transplant
Liver: Shunt
Ovaries (Oophorectomy): Endometriosis
Ovaries (Oophorectomy): Ovarian Cancer
Ovaries (Oophorectomy): Ovarian Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate Biopsy
Prostate Cancer
Prostate TURP
Rectum: APR
Rectum: Low Anterior Resection
Skin: Basal Cell Carcinoma
Skin: Melanoma
Skin: Skin Biopsy
Skin: Squamous Cell Carcinoma
Spleen (Splenectomy)
Testicles (Orchiectomy)
Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer
Uterus (Hysterectomy): Cervical Cancer
Other: _____

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Patient Name: _____ Date of Birth: _____

Skin Disease History: (Circle all the apply)

Actinic Keratosis
Acne
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking / Itchy Scalp
Hay Fever / Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Other: _____

Do you wear sunscreen? (Circle one) Yes / No If yes, what SPF? _____

Do you tan in a tanning salon? (Circle one) Yes / No

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

Alerts: Please circle all that apply:

Allergy to Lidocaine
Allergy to topical antibiotics
Blood Thinners
Defibrillator
Fever / Chills / Night Sweats
Immunosuppression
Malaise
Muscle Weakness
MRSA HX
New Growths or Lesions
Pacemaker
Problems with scarring
Problems with bleeding
Problems with healing
Pregnancy or planning pregnancy
Premedication prior to procedure
Other: _____

Current Medications:

_____/Dosage: _____
_____/Dosage: _____
_____/Dosage: _____
_____/Dosage: _____
_____/Dosage: _____
_____/Dosage: _____
_____/Dosage: _____

Do you have any allergy to bee or wasp venom? (circle one) Yes/No

Do you have any **ALLERGIES** to Medications? (Circle one) Yes / No If yes, which medication(s)?

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Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY (Circle all that apply):

Cigarette Smoking: Never Former Smoker Less than Daily Daily

Alcohol Use: None Less than 1 per day 1-2 per day 3 or more per day

*In the past year, how many times have you had 5 or more drinks for MEN or 4 or more drinks for WOMEN in a 24-HOUR PERIOD? _____

Exercise: Once a day Several times a day Few times a week Few times a month Never

Caffeine Use: Once a day Several times a day Few times a week Few times a month Never

Occupation: _____

Preferred Pharmacy Name: _____/_____
City, State, and Zip Code

Primary Care Provider Name: _____ / Location: _____

Have you had a Flu Shot? (Circle one) This Season Previous Flu Season Never: I Refuse I'm Allergic

Do you have a current pneumonia vaccination? (Circle one) Yes / No

May we leave sensitive information about your treatment on your voicemail? (Circle one) Yes / No

If yes, please leave phone number here: _____

Permission to Release Medical Information:

I authorize Bella Derma Professional LLC to share medical information such as diagnoses, treatments, test results, and any other details of my medical care with the following FAMILY / FRIENDS / INTERESTED PARTY:

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____