**Rhonda Rand MD Inc**
**Patient History**

**Patient Name:** _____ **(please print)**
**Last** **First** **M.I.**

**Past Medical History**: (please circle/fill in all that apply)

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

**If none of the above apply, please check here**: ☐

**Past Surgical History**: (please circle all that apply)

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast: Breast Biopsy
Breast Mastectomy (Right, Left, Bilateral)
Breast Lumpectomy(Right, Left, Bilateral)
Colon(Colectomy) Colon Cancer Resection
Colon(Colectomy) Diverticulitis
Colon(Colectomy) IBD
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 (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)
Kidney: Kidney Biopsy
Kidney: Kidney Stone Removal
Kidney: Kidney Transplant
Kidney: Nephrectomy
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries(Oophorectomy): Endometriosis
Ovaries(Oophorectomy): Ovarian Cancer
Ovaries(Oophorectomy): Ovarian Cyst
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate(Prostatectomy): Prostate Biopsy
Prostate(Prostatectomy): Prostate Cancer
Prostate (Prostatectomy) TURP
Rectum: APR
Rectum: Lower 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:**_____

**If none of the above apply, please check here:** ☐

**See back side**

**Skin Disease History**: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma – Year diagnosed: _____
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Other _____

**If none of the above apply, please check here**: ☐

Do you wear Sunscreen? ☐ Yes or ☐ No
If yes, what SPF? _____
Do you or have you ever tanned in a tanning salon? ☐ Yes or ☐ No

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

**Social History**: (Please check all that apply)

Cigarette Smoking:
- ☐ Never smoked
- ☐ Smokes less than daily
- ☐ Smokes daily
- ☐ Quit: former smoke

Alcohol Use:
- ☐ Alcohol: none
- ☐ Alcohol: less than 1 drink a day
- ☐ Alcohol: 1-2 drinks a day
- ☐ Alcohol: 3 or more drinks a day

Recreational Drug Use: ☐ Yes or ☐ No
Sexually Active: ☐ Yes or ☐ No
IV Drug Use: ☐ Yes or ☐ No
Do you feel safe at home: ☐ Yes or ☐ No

Any other family history: _____

_____

What soap do you use? _____

What moisturizer do you use? _____

Do you have a pet? _____

**Patient Signature** **Date**