Paul D. Revis, M.D., FAAD

1055 Featherstone Rd.
Rockford, IL 61107
(815) 227-1055

New Patient Intake

Name: ____ Date of Birth:___________

Yes	No	No, Quit	
❑	❑		Have you had the pneumococcal vaccine?
❑	❑		Are you breastfeeding?
❑	❑		Do you have a pacemaker or defibrillator?
❑	❑		Are you on chemotherapy or are you taking medications that may suppress your immune system, such as prednisone or cellcept?
❑	❑		Do you take warfarin, Coumadin, or Pradaxa?
❑	❑		Do you take aspirin or Plavix?
❑	❑		Do you bleed easily with difficulty stopping?
❑	❑		Do you have a history of MRSA?
❑	❑		Have you been instructed to take antibiotics prior to procedures?
❑	❑		Do you have any replaced joints, such as a hip or a knee?
❑	❑		Are you allergic to lidocaine or epinephrine?
❑	❑		Do you have any moles changing in size, shape or color?
❑	❑	❑	Do you smoke?

Medical Conditions

Check any of the medical conditions listed below that you have or: ❑ None

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Bone Marrow Transplant
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Heart Disease
- ❑ Depression
- ❑ Diabetes
- ❑ Enlarged Prostrate
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ High Cholesterol
- ❑ HIV/AIDS
- ❑ Hypertension
- ❑ Kidney Disease
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid Disease

Other: ____

Medication

List **allergies** to medications or: ❑ No known allergies to medications

____

____

List all of your **prescription** medications or provide the nursing staff with a written list when you are taken back to see the doctor or: ❑ No prescription medication

____

____

Pharmacy of choice (to send electronic prescriptions): ______________________________

Surgeries

Check any of the surgeries that you have had or: ❑ None

- ❑ Appendix
- ❑ Bladder

Breast

Mastectomy ❑ Right ❑ Left
Lumpectomy ❑ Right ❑ Left

- ❑ Bioposy
- ❑ Reduction
- ❑ Implant

Colectomy

- ❑ Diverticulitis
- ❑ Inflammatory Bowel Disease
- ❑ Colon cancer

- ❑ Gallbladder

Heart

- ❑ Bypass
- ❑ Stenting
- ❑ Valve Replacement
- ❑ Transplant

Joint Replacement

Knee ❑ Right ❑ Left
Hip ❑ Right ❑ Left

Kidney

- ❑ Biopsy
- ❑ Nephrectomy
- ❑ Stone Removal
- ❑ Transplant

- ❑ Hysterectomy: Endometriosis/Cancer
- ❑ Ovarian Cyst
- ❑ Ovarian Cancer

Prostate

- ❑ Biopsy
- ❑ Cancer
- ❑ TURP

- ❑ Splenectomy

- ❑ Testicular

Other: ____

Past Dermatology History

Previous skin biopsy(s), date/diagnosis:____

History of Basal Cell Carcinoma (list location and year treated): ____________________________________

History of Squamous Cell Carcinoma:____

History of Melanoma:____

Yes	No	
❑	❑	Do you have a Family history of malignant melanoma?
❑	❑	Have you had atypical or dysplastic moles removed in the past?
❑	❑	Have you used tanning beds on a regular basis?
❑	❑	Do you consistently use a sunblock to protect you skin when outdoors?