

PA Dedicated Dermatology PC

PATIENT INFORMATION

PATIENT'S NAME: _____ Today's Date: _____

Date of Birth: ____/____/____ (mm/dd/yyyy)

Gender: Male Female
Language: English Spanish Other: _____
Marital Status: Single Married Divorced Widow Separated

RACE: Please Check
 White Black or African American
 American Indian or Alaska-Native Native-Hawaiian or other Pacific Islander
 Asian Other

ETHNICITY: Please Check
 Hispanic or Latino Non-Hispanic or Latino

PHONE NUMBERS:
Home _____ Cell _____ Work _____

Preferred phone: please check
 Home Cell Work

Email: _____

Is it OK to leave a detailed message?
 YES or NO

PRIMARY CARE PHYSICIANS INFORMATION:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

IS YOUR REFERRING PHYSICIAN THE SAME AS YOUR PRIMARY CARE PHYSICIAN? YES OR NO

IF THIS IS YOUR FIRST VISIT ONLY: DOES YOUR INSURANCE REQUIRE A REFERRAL? YES OR NO

PHARMACY INFORMATION:

Name: _____
Street/City: _____
State: _____, Zip Code _____

PAST MEDICAL HISTORY

Please **check** any of the following medical conditions that you currently have:

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation (Irregular heartbeat)
- BPH (benign enlarged prostate)
- Bone Marrow Transplantation
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- Hypertension
- HIV/Aids
- Hypercholesterolemia (high cholesterol)
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- Other _____

SURGICAL HISTORY:

Please list any surgeries you have had in the past? If so please list:

SKIN DISEASE HISTORY

Please **check** if you have had any of the following skin conditions:

- Acne
- Actinic Keratosis
- Asthma
- Basal Cell Carcinoma
- Blistering Sunburn
- Dry Skin
- Eczema
- Other _____
- Flaky or itchy scalp
- Hay fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer

Do you wear Sunscreen?

(Please check) YES or NO

If yes, what SPF? _____

Do you tan in tanning salon?

(Please check) YES or NO

FAMILY HISTORY:

Do you have a family history of Melanoma?

(Please check) YES or NO

If yes, which relative?

- Mother
- Brother
- Uncle
- Niece
- Father
- Daughter
- Aunt
- Grandmother
- Sister
- Son
- Nephew
- Grandfather

MEDICATIONS: (Please list- if you have a list with you, document, see list, and give to nurse in exam room)

ALLERGIES:

Social History:

FEMALES ONLY: Last menstrual period (LMP): _____ Menopausal: Yes or No

SMOKING HISTORY: (Please Check)

- | | | |
|---|--|---|
| <input type="checkbox"/> Current every day smoker | <input type="checkbox"/> Former smoker | <input type="checkbox"/> Smoker: current status unknown |
| <input type="checkbox"/> Current someday smoker | <input type="checkbox"/> Never smoker | <input type="checkbox"/> Unknown if ever smoked |

Please check Yes or No if you have any of the following:

- | | | | |
|---|------------------------------|-----------------------------|------------------------------|
| Pacemaker | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Defibrillator | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Premedication prior to procedure | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Allergy to adhesive | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Blood thinners | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Pregnancy or planning a pregnancy | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> N/A |
| Allergy to lidocaine | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Allergy to Latex | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Rapid heartbeat with epinephrine | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Melanoma History | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| IF yes: | | | |
| Date: _____ Lymph node mapping _____ | | | |
| Immunosuppressant | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Problems with bleeding | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Artificial joints within past two years | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Artificial heart valve | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |
| Allergy to topical antibiotic ointment | <input type="checkbox"/> YES | <input type="checkbox"/> NO | |

Patient is NOT their own POA (Power of Attorney)

- YES NO

REASON FOR YOUR VISIT TODAY:
