Center for Dermatology – Specializing in Medical and Surgical Treatment of Skin Diseases

PATIENT INFORMATION DATE: _____

PATIENT'S LEGAL NAME: _____

DATE OF BIRTH: ____/____/____ AGE: _____ SS#: _____

SEX: MALE ____ FEMALE ____ MARITAL STATUS: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ OK TO LEAVE VOICEMAIL: YES ___ NO ___

EMAIL: _____ PLACE OF EMPLOYMENT: _____

EMERGENCY CONTACT NAME/PHONE: _____

PRIMARY INSURANCE CARRIER: _____ PLAN/GROUP #: _____

POLICY HOLDER'S NAME: _____ DOB: _____

POLICY HOLDER'S SS# (IF OTHER THAN PATIENT): _____

SECONDARY INS. CARRIER: _____ PLAN/GROUP #: _____

POLICY HOLDER'S NAME/SSN: _____ DOB: _____

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH FAMILY MEMBERS? YES _____ NO _____

IF YES, PLEASE PROVIDE THEIR NAMES AND PHONE NUMBERS:

NAME: _____ RELATIONSHIP: _____ PHONE# _____

NAME: _____ RELATIONSHIP: _____ PHONE# _____

NAME, PHONE #, LOCATION OF YOUR PHARMACY:_____

DOCTOR WHO REFERRED YOU: _____

ANY OTHER PERSON WHO MAY HAVE REFERRED YOU: _____

ANSWERS ARE REQUIRED:

RACE: _____(DECLINE _____) PREFERRED LANGUAGE: _____

ETHNICITY: HISPANIC _____ NON-HISPANIC _____ (DECLINE _____)

SIGNATURE OF PATIENT OR AUTHORIZED GUARDIAN: _____

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HEALTH HISTORY DATE: _____

REASON FOR VISIT: (WHAT BRINGS YOU TO THE OFFICE TODAY?)

_____

CURRENT MEDICATIONS: _____ _____

_____ _____ _____

ALLERGIES TO MEDICATIONS: _____ _____

PAST MEDICAL HISTORY: (DO YOU HAVE OR HAVE YOU EVER HAD? (CHECK IF YES)

__ AIDS/HIV
__ ANEMIA
__ ARTHRITIS
__ ASTHMA
__ CANCER
__ DIABETES
__ DEPRESSION
__ HEART DISEASE
__ HEPATITIS (A, B, OR C)
__ HIGH BLOOD PRESSURE
__ JOINT DISEASE
__ KIDNEY DISEASE
__ LIVER DISEASE
__ LUPUS
__ MULTIPLE SCLEROSIS
__ GASTROINTESTINAL DISEASE
__ PACEMAKER
__ SEIZURES
__ STROKE
__ THYROID DISEASE
__ TUBERCULOSIS
__ STDs
__ BLEEDING DISORDER
__ AUTOIMMUNE ISSUE

PAST SKIN HISTORY: (HAVE YOU EVER HAD?) (CHECK IF YES)

__ NONE
__ MELANOMA
__ ECZEMA
__ PSORIASIS
__ BASAL CELL CARCINOMA
__ SQUAMOUS CELL CARCINOMA
__ CONNECTIVE TISSUE DISORDER
__ SEXUALLY TRANSMITTED DISEASE
__ OTHER/UNKNOWN
_____

LIFESTYLE HISTORY: ARE YOU PREGNANT OR NURSING?_____

DO YOU DRINK ALCOHOL REGULARLY? DAILY ____ WEEKLY ____ RARELY ____

HAVE YOU EVER SMOKED? CURRENT ____ PAST SMOKER ____ NEVER ____

HAVE YOU EVER USED RECREATIONAL DRUGS? _____ IV DRUG USE? _____

FAMILY HISTORY:

SKIN CANCER (TYPE IF KNOWN) _____ PSORIASIS _____

LUPUS _____ ECZEMA _____ ARTHRITIS _____

SIGNATURE: _____ DATE: _____

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