Today's Date:

Patient's Information

Title: Mrs / Mr / Ms / Miss / Dr / Other_____

Name: First_____ Middle_____ Last_____ Suffix____

Preferred name or nickname: _____

Date of Birth: Month_____ Day_____ Year_____ Social Security #:_____

Gender: Male / Female Marital Status: Single / Married / Widowed / Divorced

Home Address: Number and Street:_____ Apt/Unit #:_____

City:_____ State: __OH Other:_____ Zip Code:_____

Phone (Circle Preferred) Home #_____ Cell #_____ Work #_____

Can we leave detailed messages including the patient's medical information on the voicemail or answering machine? __Yes __No	Emergency Contact: Name:_____ Phone#_____ Relationship to patient:_____
Who can receive the patient's detailed medical information?:	
Who lives in the patient's household?:	Patient's preferred language: __ English Other:_____
How did you find out about us?_____ Referring Provider:_____ Patient's Primary Care Provider:_____	Optional Patient Information Occupation:_____ Race:_____ Ethnicity:_____

Name of Insured (If different from patient):_____ Date of Birth of insured:_____
The patient is the insured person's: __SELF __SPOUSE __CHILD __PARENT __OTHER:

Primary Health Insurance:	Secondary Health Insurance:	Tertiary Health Insurance:
_____ ID#_____ Group#_____	_____ ID#_____ Group#_____	_____ ID#_____ Group#_____

Pharmacy Name:_____ City:_____ Street:_____

PLEASE TURN PAGE OVER AND FILL OUT OTHER SIDE

Reason for today's visit:

Allergies to Medications:	**Current Medications** (Let us copy your list if you have one):

Past Medical History:

__Anxiety	__COPD	__High blood pressure	__Prostate cancer
__Arthritis	__Coronary artery disease	__High cholesterol	__Radiation treatment
__Asthma	__Depression	__HIV/AIDS	__Seizures
__Atrial fibrillation	__Diabetes	__Kidney disease	__Stroke
__Bone marrow transplant	__GERD/Heartburn	__Leukemia	__Hypothyroid
__Breast Cancer	__Hearing loss	__Lung Cancer	__Hyperthyroid
__Colon Cancer	__Hepatitis	__Lymphoma	__NONE
			__Other:_____

Past Surgical History:

__Appendix Removed	__Coronary Artery Bypass	__Ovaries Removed	__Hysterectomy
__Gallbladder Removed	__Heart Valve Replaced	__Prostate Biopsy	__NONE
__Bladder Removed	__Joint Replacement	__Prostate Removal	__Other: _____
__Breast Biopsy	__Kidney Biopsy	__Spleen Removed	
__Mastectomy	__Kidney Removal	__Testicle Removed	
__Colon Surgery	__Organ Transplant	__Tubal Ligation	

Skin Disease History:

__Abnormal Scarring/Keloid	__Basal Cell Cancer	__Flaking or Itchy Scalp	__Squamous Cell Cancer
__Acne	__Blistering Sunburns	__Melanoma	__NONE
__Actinic Keratoses	__Dry Skin	__Poison Ivy	__Other:_____
__Atypical/Dysplastic Moles	__Eczema/Sensitive Skin	__Psoriasis	

Sun Protection:	**Cigarette/Tobacco Use**	**Alcoholic Drinks Per Day:**
Do you wear Sunscreen? __Yes __No SPF: _____ Do you tan in a tanning salon? __Yes __No Do you have a family history of melanoma? __Yes __No If yes, which relative? _____	__ Current Smoker __ Former Smoker __ Never Smoked	__ None __ Less than 1 __ 1-2 __ 3 or more

Alerts:

__Allergy to adhesive	__Artificial joint	__Require antibiotics before surgery	
__Allergy to lidocaine	__Blood thinners	__Rapid heartbeat with epinephrine	
__Allergy to topical antibiotics	__Defibrillator	__Pregnant/trying to get pregnant	
	__Pacemaker		
__Artificial heart valve	__MRSA		

Family History:	**Relative:**
__Eczema	_____
__Psoriasis	_____
__Skin Cancer	_____
__Diabetes	_____
__Other	_____