Today's Date: _____

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

Name: First_____ Middle_____ Last_____ Suffix_____

Preferred name or nickname: _____ Date of Birth: Month_____ Day_____ Year_____

Sex: Male / Female Gender Identity:_____ Marital Status: Single / Married / Divorced / Widowed

Address:_____ Apt/Unit #:_____

City:_____ State:_____ Zip Code:_____ Email:_____

Phone (Circle Preferred): Home_____ Cell_____

Responsible Party:
Name_____ DOB: _____ Relationship to Patient_____

Address_____ Phone_____

Can we leave detailed messages, including the patient's medical information, on the voicemail or answering machine? ___Yes ___No

Who can receive the patient's detailed medical information?

_____

Who lives in the patient's household?

_____

Emergency Contact:

Name_____

Phone_____

Relationship to patient_____

Optional Information:

Occupation_____

Race_____

Ethnicity_____

How did you find out about us? _____

Referring Provider: _____

Primary Care Provider: _____

Primary Health Insurance:

_____

ID #_____

Group #_____

Subscriber _____

Subscriber DOB_____

Relationship to patient_____

Secondary Health Insurance:

_____

ID #_____

Group #_____

Subscriber _____

Subscriber DOB_____

Relationship to patient_____

Tertiary Health Insurance:

_____

ID #_____

Group #_____

Subscriber_____

Subscriber DOB_____

Relationship to patient_____

Pharmacy: Name_____ City:_____ Street:_____

OVER ➔

Reason for today's visit:

Current Medications: ___ None ___ List copied by receptionist ___ Meds listed in space below:

Allergies to Medications: ___ None ___ Allergies listed here:

Past Medical History:

___None
___Allergies to pollen
___Anxiety
___Arthritis
___Asthma
___Atrial fibrillation
___Prostate enlargement
___Stroke
___Liver disease
___COPD
___Coronary artery disease
___Depression
___Diabetes
___Epilepsy
___GERD/ heartburn
___High blood pressure
___Hearing loss
___HIV/AIDS
___High cholesterol
___Hyperthyroidism
___Hypothyroidism
___Immunosuppression
___Crohns/Ulcerative colitis
___Kidney disease
___Leukemia
___Lymphoma
___Breast cancer
___Colon cancer
___Lung cancer
___Prostate cancer
___Radiation therapy
___Schizophrenia
___Lupus
___Bone marrow transplant
___Hepatitis
___Other:

Past Surgical History:

___None
___Appendix removed
___Bladder removed
___Gallbladder removed
___Colostomy
___Coronary artery bypass
___Coronary artery stent
___Heart valve replaced
___Colon removed
___Hysterectomy
___Kidney removed
___Liver removed
___Lumpectomy: R/L
___Mastectomy: R/L
___Ovaries removed
___Pancreas removed
___Prostate removed
___Spleen removed
___Testicles removed
___Joint replacement: Joint_____ Date____
___Organ transplant: Organ_____
___Tubal ligation
___Other:

Skin Disease History:

___None
___Acne
___Actinic keratosis
___Basal cell carcinoma
___Poison ivy
___Atypical Moles
___Eczema
___Melanoma
___Scalp itching
___Psoriasis
___Squamous cell carcinoma
___Blistering sunburn
___Other:

Sun Protection:
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? _____

Cigarette/Tobacco Use:
___Current Smoker
___Former Smoker
___Never Smoked

Alcoholic Drinks Per Day:
___None
___Less than 1
___1-2
___3 or more

Alerts:
___Allergy to adhesive
___Allergy to latex
___Allergy to lidocaine
___Allergy to antibiotic ointments
___Artificial heart valve
___Artificial joint
___Blood thinners
___Defibrillator
___Breast feeding
___MRSA
___Pacemaker
___Rapid heartbeat with epinephrine
___Pregnant/Trying to get pregnant
___Require antibiotics before surgery

Family History: Relative:
___Eczema _____
___Psoriasis _____
___Skin Cancer _____
___Diabetes _____
___Heart disease _____
___Cancer _____
___Other: _____