

Today's Date: _____

Title: Mr. / Mrs. / Ms. / Miss / Dr. / Other _____ SSN _____

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 _____

How did you find out about us? _____

Referring Provider: _____

Primary Care Provider: _____

Optional Information:
 Occupation _____
 Race _____
 Ethnicity _____

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: _____

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: _____