A to Z Dermatology

PATIENT INFORMATION

Name: _____ _____ _____
First Name | Middle Name Initial | Last Name

Date of Birth: ____/____/____ Sex: Male/Female SS #____-____-____

Marital Status: Single Married Divorced/Separated Widowed

Address: _____ ____ _____ _____ _____
Street | Apt # | City | State | Zip Code

Phone Numbers: (____) _____ (____) _____
Home | Cell

Email Address: _____ (gives you access to portal/medical records only)

Would you like to receive e-mails regarding special events and discounted cosmetic services? YES/NO

EMERGENCY CONTACT

Name: _____ Phone #: (____) _____ Relationship: _____

Is it okay to give your emergency contact your Biopsy Results? YES/NO

MEDICAL INSURANCE (S)

Primary Insurance Co: _____ ID #: _____ Group #: _____

Secondary Insurance Co: _____ ID #: _____ Group #: _____

PRIMARY CARE PHYSICIAN

Full Name: _____

Office Phone: _____ Office Fax: _____

Did this Doctor refer you? YES/NO If NO, how did you hear about us? _____

PREFERRED PHARMACY

Name: _____ Major Cross Roads: _____

Phone: (____) _____ Fax: (____) _____

TURN OVER, QUESTIONS ON BACK SIDE

A to Z Dermatology

CURRENT MEDICATIONS

Name of Drug	Strength	Frequency

CURRENT DRUG ALLERGIES

Name of Drug/Object	Reactions (CHECK ONLY THOSE THAT APPLY)							
	*Anaphylaxis	*Diarrhea	*Fatigue	*Upset GI	*Hives	*Liver Toxicity	*Rash	*Other
	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	

A to Z Dermatology

REVIEW OF SYSTEMS
(CHECK ONLY THOSE THAT APPLY)

- ☐ Fevers/Chills
- ☐ Night Sweats
- ☐ Unintentional Weight Loss
- ☐ Cough
- ☐ Abdominal Pain
- ☐ Joint Aches
- ☐ Problems with Scarring (Hypertrophic or Keloid)
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Headaches
- ☐ Sore Throat
- ☐ Anxiety
- ☐ Muscle Weakness
- ☐ Depression
- ☐ Vision Problems
- ☐ Hay Fever
- ☐ Seasonal Allergies

SOCIAL HISTORY
(Check those that apply)

Smoking Status

- ☐ Current Every day Smoker
  _____Cigarettes per day
- ☐ Current Someday Smoker
- ☐ Former Smoker
  _____Year you quit
- ☐ Never Smoker

Alcohol Use

- ☐ NONE
- ☐ Less Than 1 drink per day
- ☐ 1-2 Drinks per day
- ☐ 3 or more drinks per day

Caffeine Use

- ☐ Never
- ☐ One cup a day
- ☐ 2+ cups a day

PAST MEDICAL HISTORY

- ☐ Anxiety
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Asthma
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Diabetes-Type_____
- ☐ Gerd
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other:_____

TURN OVER, QUESTIONS ON BACK SIDE

A to Z Dermatology

PAST SURGERIES

- ☐ Appendectomy
- ☐ Cystectomy
- ☐ Mastectomy; R/L/Both
- ☐ Breast Biopsy; R/L/Both
- ☐ Colon Cancer Resection
- ☐ Diverticulitis
- ☐ Cholecystectomy
- ☐ Coronary Artery Bypass
- ☐ Heart Mechanical Valve Replacement
- ☐ Knee Joint Replacement; R/L/Both
- ☐ Hip Joint Replacement; R/L/Both
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovarian Cyst
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Skin Biopsy
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Melanoma Skin Cancer
- ☐ Other:_____

SKIN DISEASE

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Other: _____
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer

Do You Wear Sunscreen? YES/NO

If so what SPF? _____

Do you use a tanning salon? YES/NO

FAMILY HISTORY

Do you have any family history of Melanoma? Yes/NO

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Son
- ☐ Daughter
- ☐ Other:_____
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandfather
- ☐ Grandmother