Dermatology Associates, P.A. Check-In and Summary Sheet Date: _________________
First _____________________________M.I. ____ Last ________________________________
Address ________________________________City _________________ Zip ______________
Phone (____)______________ Work (____) ______________ Cell (____) _________________
Date of birth ___/___/___ Emergency contact ___________________ (___)_________________
SS# _____-____-_____ Primary Physician ____
E-mail address: ____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Bone Marrow Transplantation
BPH (Benign Prostatic Hyperplasia)
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Crohn's Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid Reflux)
Hearing Loss
Hepatitis
Hypertension (High Blood Pressure)
HIV / AIDS
Hypercholesterolemia (High Cholesterol)
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Ovarian Cancer
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Ulcerative Colitis
NONE

Other ____

Surgical History: (please circle all that apply)

Appendix Removal (Appendectomy)
Tonsil Removal (Tonsillectomy)
Bladder Removal (Cystectomy)
Mastectomy (Right, Left, Both)
Lumpectomy (Right, Left, Both)
Breast Biopsy
Breast Reduction
Breast Implants
C-Section (Caesarian Section)
Colon Removal (Colectomy)
Gallbladder Removal (Cholecystectomy)
Coronary Artery Bypass
PTCA
Heart Valve Replacement
Heart Transplant
Joint Replacement- Knee (Right, Left, Both) Year: ________
Joint Replacement-Hip (Right, Left, Both) Year: ________
Kidney Biopsy
Kidney Removal (Nephrectomy)
Kidney Stone Removal
Kidney Transplant
Ovary Removal (Oophorectomy)
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removal (Splenectomy)
Testicle Removal (Orchiectomy)
Uterine Removal (Hysterectomy)
NONE

Other ____

Skin Disease History: (please circle all that apply)

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer
- NONE
- Other ____

Do you wear Sunscreen? Yes NO If yes, what SPF? _______

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? ________________________

Medications: (Please enter all **current medications, strength, daily dosage**, reason for taking, or attach list): If not on any medications circle: **NONE**

Name of Medication	Strength/mg	Daily Dosage	Reason for taking

Medication Allergies: (Please enter all drug allergies)

____

____

Social History: (Please circle one)

Alcohol Use:
- None
- 2 or less per day
- more than 2 drinks per day

Cigarette Smoking:
- Never
- Former smoker
- Current every day smoker
- Current some day smoker

Have you had your FLU shot? Y/N **Pneumonia shot? Y/N**

Reason for your visit with us? ___________________________________

Are you experiencing any pain associated with this visit? Y/N if yes pain (0-10) _____

Place of Residence: (Please circle one)

- Assisted Living
- Nursing Home
- With Caretaker
- With Self
- With Spouse/Significant Other
- With Family
- Other: ____

Occupation and Workplace: ______________________________________

Gender:
Male
Female

Marital Status:
Single Divorced
Married Widowed
Separated Domestic Partner
Other_______________

Preferred Language:
English
Spanish
Other ______________

Race:
White
American Indian/Alaska Native
Asian
Black/ African American
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Not Hispanic/Latino

Pharmacy
Name: ____
Street: ________________________________ Zip Code: _______________

Please answer by putting an X in the appropriate parenthesis:

	YES	NO
allergy to adhesive	( )	( )
allergy to lidocaine	( )	( )
rapid heartbeat with epinephrine	( )	( )
allergy to topical antibiotic ointments	( )	( )
artificial heart valve	( )	( )
artificial joints within the past two years	( )	( )
pre-medicate prior to procedures	( )	( )
blood thinners	( )	( )
defibrillator	( )	( )
pacemaker	( )	( )
MRSA	( )	( )
pregnancy or planning a pregnancy	( )	( )
history of hepatitis	( )	( )
history of HIV infection	( )	( )

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Please list any family members or patient representatives you would like to share your Protected Medical Information: ____
____

Let us know if you will allow us to leave messages on your home answering machine regarding your care/pathology reports/referral appointments:

Circle one: Yes, it is okay to leave a message No, do not leave messages

FAMILY HISTORY:

(please check all that apply and check the family member with the history of illness)

	(mother)	(father)	(sister)	(brother)	(son)	(Daughter)
Asthma	( )	( )	( )	( )	( )	( )
Breast Cancer	( )	( )	( )	( )	( )	( )
Colon Cancer	( )	( )	( )	( )	( )	( )
COPD (Emphysema)	( )	( )	( )	( )	( )	( )
Coronary Artery Disease	( )	( )	( )	( )	( )	( )
Crohn's Disease	( )	( )	( )	( )	( )	( )
Depression	( )	( )	( )	( )	( )	( )
Diabetes	( )	( )	( )	( )	( )	( )
Hypertension (High Blood Pressure)	( )	( )	( )	( )	( )	( )
Hypercholesterolemia (High Cholesterol)	( )	( )	( )	( )	( )	( )
Melanoma	( )	( )	( )	( )	( )	( )
Stroke	( )	( )	( )	( )	( )	( )
Ulcerative Colitis	( )	( )	( )	( )	( )	( )