

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: _____

Please check below your preferred appointment contact preference:

Phone Call - day phone # _____ Text Cell # _____ e-mail

No Reminder

Past Medical History: (please circle all that apply)

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

Other _____

Surgical History: (please circle all that apply)

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

Other _____

Skin Disease History: (please circle all that apply)

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

<u>Name of Medication</u>	<u>Strength/mg</u>	<u>Daily Dosage</u>	<u>Reason for taking</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 | With Self |
| Nursing Home | With Spouse/Significant Other |
| With Caretaker | With Family |
| Other: _____ | |

Occupation and Workplace: _____

Gender:

Male
Female

Race:

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

Marital Status:

Single Divorced
Married Widowed
Separated Domestic Partner
Other _____

Ethnicity:

Hispanic/Latino
Not Hispanic/Latino

Preferred Language:

English
Spanish
Other _____

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	()	()

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)
(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	()	()	()	()	()	()