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
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 Covid Vaccine? 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	( )	( )

****

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

Please Circle your answers below:

Do you have a Living Will? Y/N
Do you have a Healthcare Proxy? Y/N (Someone who could make a healthcare decision on your behalf if you were unable to)

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: Date: _____

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

	(mother)	(father)	(sister)	(brother)	(son)	(Daughter)	(None)
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	( )	( )	( )	( )	( )	( )	( )