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 check 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 check 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 check 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 check 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? □Yes□No **Pneumonia shot? □Yes□No**

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 check 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
□ Separate □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 a check in the appropriate box:

	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:

Check 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	☐	☐	☐	☐	☐	☐