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	☐	☐	☐	☐	☐	☐