Parkland Dermatology
COSMETIC, MEDICAL & SKIN CANCER SPECIALISTS

Patient Information

NAME: ______________________________ TODAY'S DATE: ______________________

DATE OF BIRTH: _____/_____/_________ GENDER: ____________ MARITAL STATUS: ______________ SSN: ___________________

Phone Number HOME: ______________________________ CELL: ______________________________

** PLEASE INDICATE PREFERRED PHONE NUMBER **

Street Address: ____

City / State / Zip Code: ____

Email (please print clearly): ____

Spouse/Legal Guardian Name: ______________________________ Relationship: ______________________________

Spouse/Legal Guardian DOB: ________________ Spouse/Legal Guardian Phone: ______________________________

Emergency Contact: ______________________________ Emergency Contact PHONE: ______________________________

Primary Care Physician (PCP)

Name: ________________________

Phone Number: ________________________

City or Zip Code: ________________________

Did they refer you? Yes / No

Referring Physician

Name: ________________________

Phone Number: ________________________

City or Zip Code: ________________________

Preferred Pharmacy

Name: ________________________

Phone Number: ________________________

City / Zip Code: ________________________

IF NO PCP OR REFERRING PLEASE MARK NONE

Past Medical History

- ☐ NONE
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ OTHER:

____
____
____
____

Past Surgical History

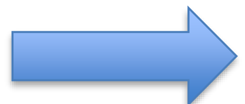
Please list any major surgical procedures:

____
____
____
____

Skin Disease History

- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Eczema
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Squamous Cell Skin Cancer

Continue on back



Patient Information

Skin Disease History

Do you have a family history of Melanoma?

☐ No

☐ Yes; if so, which relative(s) ?

____

Do you wear sunscreen?

☐ No

☐ Yes; if so, what SPF:

____

Do you tan in a tanning salon?

☐ No ☐ Yes

Medications

Please list all current medications:

By providing a medications list, this allows us permission to import your prescription history

____

____

____

____

____

____

____

____

Allergies

Are you allergic to: **LIDOCAINE** **EPINEPHRINE** **ADHESIVES** **ANTIBIOTICS** **?**

List all known Allergies AND Reactions: ____

Social History

Smoking Status (please choose one):

☐ Never smoker

☐ Current every day smoker

Number of Packs Per Day: _________

Total Years Smoking: _____________

Alcohol Intake (please choose one):

☐ None

☐ 1 or less per day

☐ 1-2 per day

☐ 3 or more per day

HAVE YOU HAD A PNEUMONIA VACCINE? YES / NO

Occupation and Workplace: ________________________________

Family History

Please indicate only 1st-degree relatives (mother, father, brother, sister, children):

☐ Skin cancer______________ ☐ Breast Cancer______________ ☐ Colon Cancer______________ ☐ Bleeding disorders _____________

☐ Other: ____

Review of Systems

Please check all that apply:

☐ Pregnant or planning a pregnancy

☐ Immunosuppression

☐ Blood thinners

☐ Defibrillator

☐ Require premedication prior to procedures

☐ Artificial joints (within past 2 years)

☐ Artificial heart valve

☐ HIV/AIDS or hepatitis

☐ Problems with healing

☐ Anxiety or depression

☐ Fevers or chills

☐ Diabetes (pre-diabetes, high blood sugar)

☐ Problems with bleeding

☐ Blurry vision

☐ Sore throat

☐ Seizures