Dermatology Associates of Central NJ &
Freehold Skin Clinic & Cancer Center

Patient Name:_____

Why are you here today?_____

Referring Physician: _____

Referring Physician Phone #___(_____)_____-_____

Primary Care Doctor: _____

Primary Care Phone #___(_____)_____-_____

When was your last visit to your primary care doctor? _____

Pharmacy Name:_____ **Phone #**_____

Street:_____ **Zip code:**_____

Date of Birth: _____ **Birth Sex:** Female or Male

Female: Date of Last Menstrual Cycle _____

Past Medical History: (Please circle all that apply)

Anxiety	End Stage Renal Disease	Leukemia
Arthritis	GERD	Lung Cancer
Asthma	Hearing Loss	Lymphoma
Atrial fibrillation	Hepatitis	Prostate Cancer
Bone Marrow Transplant	High Blood Pressure	Radiation Treatment
BPH	HIV/AIDS	Seizures
Breast Cancer	High Cholesterol	Stroke
Colon Cancer	Thyroid Problems (Hyper or Hypo)	Pacemaker
Chronic Obstructive	Depression	NONE

Do you have any of the following? (Please list all that apply):

HEART FAILURE DIABETES COPD (Pulmonary Disease) CAD (Coronary Artery Disease)

Past Surgical History: (Please list all that apply)

_____

_____

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Skin Disease History: (Please circle all that apply)

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

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No
List all that apply: Mother Father Sister Brother Daughter Son Other

Medications: (Please enter all current medications) (Please provide list if applicable)

_____DOSE_____FREQUENCY_____
_____DOSE_____FREQUENCY_____
_____DOSE_____FREQUENCY_____
_____DOSE_____FREQUENCY_____
_____DOSE_____FREQUENCY_____

Allergies: (Please enter all allergies, ***including*** medication allergies)

_____

Have you received the flu vaccine this year?
- ☐ Yes
- ☐ No (Reason: _____

Do you have a history of Melanoma?
- ☐ Yes
- ☐ No

If yes, site treated and year:
_____

Are you on a biologic (ex: Stelara) for psoriasis?
- ☐ Yes
- ☐ No

List current height and weight.
Height: ____ ft _____ in
Weight: _____ lbs

Patients 12 and older

Tobacco Use:
- ☐ Smoker
- ☐ Non-smoker

Patients 65 and older

Do you have an Advance Care Plan/Directive?
- ☐ Yes (please name your Surrogate Decision Maker: _____
  Phone: _____
- ☐ Decline to answer

Have you EVER received the pneumonia vaccine?
- ☐ Yes
- ☐ No