ADVANCED DERMATOLOGY & SKIN CANCER CENTER

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Patient Information

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Date ______ /______ /______

Name: ____
Last *First* *M.I.*

Mailing Address: ____
City *State* *Zip*

Home Phone: (   ) ____________________ Cell Phone: (   ) ____________________

Work Phone: (   ) ____________________ E-mail: ____________________

Primary Care Physician: ____________________ Referring Physician: ____________________

Date of Birth: _____ /_____ /_____ Sex: ☐ Male ☐ Female Social Security # ____________________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Other

Employment Status: ☐ Working PT ☐ Working FT ☐ Disabled ☐ Unemployed ☐ Student PT ☐ Student FT ☐ Retired

Race: ☐ White ☐ Hispanic ☐ African American ☐ Asian ☐ Other ____________________

Language: ☐ English ☐ Spanish ☐ Other ____________________

Employer Name: ____________________ Phone: ____________________

Emergency Contact ____________________ Relationship __________ Emergency Phone # ____________________

RESPONSIBLE PARTY INFORMATION (if different from patient) RELATIONSHIP ____________________

Name: ____ Date of Birth: _____ /_____ /_____ /
Last *First* *M.I.*

Mailing Address ____________________ City __________ State ______ Zip __________

Home Phone: (   ) ____________________ Work Phone: (   ) ____________________

How did you hear about our practice? ☐ Yellow Pages ☐ Newspaper ☐ Friend/Patient ☐ Citiscapes ☐ Internet ☐ Revive Medical Spa ☐ Physician ☐ Other ____________________

INSURANCE INFO: Do you have health insurance? ☐ Yes ☐ No Guarantor is the person whose NAME is on the insurance card.

Primary Insurance Company: ____________________ **Secondary Insurance Company:** ____________________

Insurance ID Number: ____________________ Insurance ID Number: ____________________

Insurance Group Number: ____________________ Insurance Group Number: ____________________

Name of Guarantor: ____________________ Name of Guarantor: ____________________

Relationship to Patient: ____________________ Relationship to Patient: ____________________

Guarantor Social Security Number: ____________________ Guarantor Social Security Number: ____________________

Guarantor Date of Birth: ____________________ Guarantor Date of Birth: ____________________

Pharmacy of Choice: ____
Name *Address*

Please present your insurance card(s) and a photo ID to the receptionist along with this completed form.

Medical History

Name: ______________________ Date: ______ / ______ / ______

Date of Birth __________ What is the reason for your visit today? ______________________

PAST MEDICAL HISTORY — PLEASE CHECK ALL THAT APPLY

☐ Anxiety
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Atrial fibrillation
☐ BPH
☐ Bone marrow transplant
☐ Breast cancer
☐ Colon cancer
☐ COPD
☐ Coronary artery disease
☐ Depression
☐ Diabetes
☐ End stage renal disease
☐ GERD
☐ Hearing loss
☐ Heart attack
☐ Hepatitis
☐ Hypertension
☐ HIV/AIDS
☐ Hypercholesterolemia
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Leukemia
☐ Lung cancer
☐ Lymphoma
☐ Pacemaker
☐ Prostate cancer
☐ Radiation treatment
☐ Seizures
☐ Stroke
☐ Other ______________________

PAST SURGICAL HISTORY: PLEASE CHECK ALL THAT APPLY

☐ Appendix removed
☐ Bladder removed
☐ Mastectomy (Right, left, both)
☐ Lumpectomy (Right, left, both)
☐ Breast Biopsy (Right, left, both)
☐ Breast reduction
☐ Breast implants
☐ Colectomy: Colon cancer resection
☐ Colectomy: Diverticulitis
☐ Colectomy: IBD
☐ Gallbladder removed
☐ Coronary artery bypass
☐ PTCA / stents
☐ Mechanical valve replacement
☐ Biological valve replacement
☐ Heart transplant
☐ Joint replacement knee right, left, both
☐ Joint replacement hip, right, left, both
☐ Joint replacement within last 2 years
☐ Kidney biopsy/transplant
☐ Kidney removed (right/left)
☐ Kidney stone removal
☐ Ovaries removed: endometriosis
☐ Ovaries removed: cyst
☐ Ovaries removed: ovarian cancer
☐ Prostate removed: prostate cancer
☐ Prostate biopsy
☐ TURP
☐ Skin biopsy
☐ Liver transplant
☐ Basal cell cancer surgery
☐ Squamous cell cancer surgery
☐ Melanoma surgery
☐ Spleen removed
☐ Testicles removed (right, left, both)
☐ Hysterectomy: fibroids
☐ Hysterectomy: uterine cancer
☐ None
☐ Other______________________

SKIN DISEASE HISTORY: PLEASE CHECK ALL THAT APPLY

☐ Acne
☐ Actinic keratoses
☐ Asthma
☐ Basal cell carcinoma
☐ Blistering sunburns
☐ Flaking or itchy scalp
☐ Hay fever/allergies
☐ Melanoma
☐ Poison ivy
☐ Precancerous mole
☐ Squamous cell skin cancer
☐ Psoriasis
☐ Eczema
☐ Dry skin
☐ Other______________________

Family history of melanoma ☐ Yes ☐ No
*If yes, which member*______________________
Family history of skin cancer ☐ Yes ☐ No
Family medical history and person's relationship to you?

Female Patients:
Are you currently pregnant? ☐ Yes ☐ No
Date of Last Menstrual Cycle: ____________

Currently or have had MRSA ☐ Yes ☐ No
Recieved flu shot this year ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No
Former smoker ☐ Yes ☐ No
Never smoked? ☐ Yes ☐ No
Illicit drug use ☐ Yes ☐ No

Alcohol use ☐ None
☐ Less than one drink per day
☐ 1-2/day ☐ 3+/day

CURRENT MEDICATIONS: Names (include OTC, herbal, vitamins)
1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

DRUG ALLERGIES: Names, Reaction (rash, hives, nausea, etc)
1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

REVIEW OF SYSTEMS

☐ Abdominal pain
☐ Angina
☐ Prolonged bleeding
☐ Skin growths
☐ Shortness of breath
☐ Seizures
☐ Vomiting
☐ Weight loss (unintentional)
☐ Ulcers
☐ Arthritis
☐ Diabetes
☐ Hypertension
☐ Thyroid
☐ Osteoporosis
☐ Defibrillator/Pacemaker
☐ Ambulate with cane
☐ Abnormal wound healing
☐ Bloody bowel movement
☐ Chills
☐ Chest pain
☐ Change in vision
☐ Chronic rash
☐ Cough
☐ Dizziness/fainting
☐ Difficulty hearing
☐ Depression
☐ Diarrhea
☐ Difficult sleeping
☐ Ear pain
☐ Fevers
☐ Fainting
☐ Headache
☐ Heart palpitation
☐ Indigestion/reflux
☐ Incontinence
☐ Inability to urinate
☐ Joint swelling
☐ Loss of consciousness
☐ Muscle pains
☐ Night sweats
☐ Numbness
☐ Nausea
☐ Painful urination
☐ Painful bowel movement
☐ Paralysis
☐ Glaucoma
☐ Double vision
☐ Joint pains