BEAIRD
dermatology

Patient Name: Date of Birth: Height: Weight:

Primary Care Physician: Referring Physician:

Reason for visit: Today's Date:

Pharmacy: **Mail Order Pharmacy**:

Allergies: **YES** **NO** If yes, Please list:

If you allow us to import your prescription history it is not necessary for you to list your **prescription** medications.

Medications:

Past Medical History - Select any of the following medical conditions that you currently have

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Dx
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Dx
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ **None**

Past Surgeries

- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Other Surgery:_____

Have you had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ 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
- ☐ Other: _____
- ☐ **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**

If yes, which relative(s)? _____

Smoking Status

- ☐ Current Every Day Smoker
- ☐ Former Smoker
- ☐ Never Smoked

Social History Details

- ☐ Not sexually active
- ☐ Sexually active with one partner
- ☐ Sexually active with more than one partner

Alcohol Consumption

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Men - How many times in the past year have you had 5 or more drinks in a day? _____

Women and adults older than 65 years - How many times in the past year have you had 4 or more drinks in a day? _____

Influenza (Flu) Vaccine - Select the one that best fits:

- ☐ Received a flu vaccine this season.
- ☐ Did NOT receive a flu vaccine this season.

Pneumococcal Vaccine (for patients 65 and older **ONLY**)

- ☐ Received a Pneumococcal Vaccine (Pneumovax).
- ☐ Did NOT receive a Pneumococcal Vaccine.

Other Vaccines (For patients who are EXACTLY 13 years old) if you are not currently 13 years old, please skip this question.

- ☐ Received one dose of meningococcal vaccine on or between 11-13th birthday.
- ☐ Received one tetanus, diphtheria and pertussis vaccine (Tdap) on or between 10th and 13th birthdays.
- ☐ Received at least three HPV vaccines on or between my 9th and 13th birthdays.

Advanced Directives

Advanced directives are designed to respect your autonomy and determine your wishes about future life-sustaining medical treatment if you are unable to indicate your wishes. Key interventions and treatment decisions are: resuscitation procedures such as Cardiopulmonary Resuscitation (CPR), and mechanical respiration (breathing tube).

Which statement(s) **best reflects** your wishes on advanced care recommendations?

- ☐ **Full Code**: I want full cardiopulmonary resuscitation efforts to be made.
- ☐ **Do not Intubate**: I do not wish to have a breathing tube, even if it is necessary to save my life.
- ☐ **Do not Resuscitate**: If my heart were to stop, I do not wish to have chest compressions or automated external defibrillator to restart my heart even if it's necessary to save my life.
- ☐ I have a living will.
- ☐ I have a health care proxy whose name is _____, and contact information is _____