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 #___**(**_____**)**_____**-**_____

Primary Care – MONTH/YEAR of last visit: _____ **/**_____

Have you been hospitalized since your last visit? YES or NO

If YES, please give reason for hospitalization: _____

_____

Pharmacy Name:_____ **Phone #**_____

Street:_____ **Zip code:** _____

Date of Birth: _____ **Gender:** 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 ***CIRCLE*** all that apply):

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

Past Surgical History: (please list all that apply):

_____

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 history of Melanoma? 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):
_____DOSE_____FREQUENCY_____
_____DOSE_____FREQUENCY_____
_____DOSE_____FREQUENCY_____
_____DOSE_____FREQUENCY_____
_____DOSE_____FREQUENCY_____

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

_____

All Patients

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

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

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: _____
- ☐ Decline to answer

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