



TODAY'S DATE: _____

PATIENT INFORMATION

LAST NAME: _____

FIRST NAME: _____

☐

MALE

☐

FEMALE

DATE OF BIRTH: _____

MARITAL STATUS: SINGLE

MARRIED

DIVORCED

OTHER

STREET ADDRESS: _____

APT# _____

CITY: _____

STATE: _____

ZIP CODE: _____

PRIMARY PHONE: _____

EMAIL ADDRESS: _____

DRIVER'S LICENSE NUMBER: _____

FOR MINORS

PARENT/LEGAL GUARDIAN NAME: _____

PARENT/LEGAL GUARDIAN DATE OF BIRTH: _____

INSURANCE COVERAGE

PRIMARY INSURED'S NAME: _____

PRIMARY INSURED'S DATE OF BIRTH: _____

IF REFERRED BY PHYSICIAN – FILL OUT THIS PORTION

REFERRING DOCTOR'S NAME: _____

OFFICE NUMBER _____

PATIENT NAME: _____

CHART# _____

PAST MEDICAL HISTORY

Please check all that apply.

- | | | |
|---|---|---|
| ☐ Anxiety Disorder | ☐ End Stage Renal Disease | ☐ COPD |
| ☐ Arthritis | ☐ Gastroesophageal Reflux Disease | ☐ Coronary Artery Disease |
| ☐ Autoimmune Disease | ☐ GERD | ☐ Breast Cancer |
| ☐ Asthma | ☐ Human Immunodeficiency Virus Infection | ☐ Colon Cancer |
| ☐ Atrial Fibrillation | ☐ Hypertension | ☐ Lung Cancer |
| ☐ BPH (Benign prostatic hyperplasia) | ☐ Hearing Loss | ☐ Lupus |
| ☐ Cerebrovascular Accident | ☐ HIV/AIDS | ☐ Malignant Lymphoma |
| ☐ Coronary Arteriosclerosis | ☐ High Cholesterol | ☐ Malignant Tumor of Breast |
| ☐ Disease Caused by 2019-nCov | ☐ Hepatitis | ☐ Malignant Tumor of Prostate |
| ☐ Depressive Disorder | ☐ Inflammatory Liver Disease | ☐ Malignant Tumor of Colon |
| ☐ Diabetes | ☐ Leukemia | ☐ Malignant Tumor of Lung |
| ☐ Diabetes Mellitus | ☐ Lymphoma | ☐ Radiation Therapy Treatment Management |
| ☐ High Blood Pressure | ☐ Hyperthyroidism | ☐ Transplantation of Bone Marrow |
| ☐ Elevated Blood Pressure | ☐ Hypothyroidism | ☐ Depression |
| ☐ Epilepsy | ☐ Stroke | ☐ NONE |
| ☐ OTHER _____ | | |

PAST SURGICAL HISTORY

Please check all that apply.

- | | |
|---|---|
| ☐ Abdominoperineal Resection | ☐ History of Mastectomy (right, left, bilateral) |
| ☐ Appendectomy | ☐ History of Gallbladder Removal |
| ☐ Bilateral Replacement of Knee Joints | ☐ History of Kidney Removal |
| ☐ Biopsy of Breast | ☐ History of Liver Excision |
| ☐ Biopsy of Prostate | ☐ History of Percutaneous Coronary Angioplasty |
| ☐ Colostomy | ☐ History of Transurethral Prostatectomy |
| ☐ Coronary Artery Bypass Graft | ☐ Hysterectomy |
| ☐ Excision of Basal Cell Carcinoma | ☐ Kidney Biopsy |
| ☐ Excision of Melanoma | ☐ Low Anterior Resection of Rectum |
| ☐ Excision of Squamous Cell Carcinoma | ☐ Lumpectomy (right, left, bilateral) |
| ☐ History of Appendectomy | ☐ Mechanical Heart Valve Replacement |
| ☐ History of Bladder Removal | ☐ Oophorectomy |
| ☐ History of Colectomy | ☐ Ovary Removal (right, left, bilateral) |
| ☐ History of Cholecystectomy | ☐ History of Pancreatectomy |
| ☐ History of Cystectomy | ☐ Kidney Stone Removal |
| ☐ History of Heart Valve Replacement | ☐ Kidney Transplant |
| | ☐ Portosystemic Shunt Operation |

- | | |
|---|--|
| ☐ Prostatectomy | ☐ Knee replacement (Right, Left, Bilateral) |
| ☐ Hip Replacement (Right, Left, Bilateral) | ☐ Transplantation of Heart |
| ☐ Splenectomy | ☐ Transplantation of Liver |
| ☐ Surgical Biopsy of Skin | ☐ Tubal Ligation |
| ☐ Total Nephrectomy | ☐ OTHER _____ |
| ☐ Total Orchidectomy | ☐ NONE |
| ☐ Tubal Ligation | |

SKIN DISEASE HISTORY

Please check all that apply.

- | | |
|---|---|
| ☐ Acne | ☐ Hay Fever/allergies |
| ☐ Actinic Keratosis | ☐ Malignant Melanoma |
| ☐ Asteatosis Cutis | ☐ Melanoma |
| ☐ Asthma | ☐ Pre-Cancerous Moles |
| ☐ Basal Cell Carcinoma of the Skin | ☐ Pruritus of Scalp |
| ☐ Blistering Sunburn | ☐ Psoriasis |
| ☐ Contact Dermatitis Due to Poison Ivy | ☐ Squamous Cell Carcinoma |
| ☐ Dry Skin | ☐ Sunburn of Second Degree |
| ☐ Dysplastic Nevus of Skin | ☐ OTHER _____ |
| ☐ Eczema | ☐ NONE |
| ☐ Flaking/Itchy Scalp | |

SKIN HISTORY

Do you wear sunscreen on a daily basis?

☐ YES - What SPF? _____

☐ NO

Do you tan in a tanning salon?

YES ☐

NO ☐

Do you have a family history of melanoma?

YES ☐

NO ☐

If yes, which relative(s)?

- | | |
|----------------------------------|-----------------------------------|
| ☐ Mother | ☐ Daughter |
| ☐ Father | ☐ Son |
| ☐ Sister | ☐ Uncle |
| ☐ Brother | ☐ Aunt |



- ☐ Nephew
- ☐ Niece
- ☐ Grandmother

- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter

MEDICATIONS & ALLERGIES

MEDICATIONS – PLEASE ENTER ALL CURRENT MEDICATIONS.

☐ NONE

MEDICATION	STRENGTH	FREQUENCY

ALLERGIES – PLEASE LIST ANY AND ALL ALLERGIES. IF NONE – PLEASE WRITE 'NONE'.

SOCIAL HISTORY

Cigarette Smoking:

- ☐ Current every day smoker
- ☐ Current occasional smoker
- ☐ Former smoker
- ☐ Never smoked

Alcohol Use:

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

Exercise:

- ☐ Once per day
- ☐ Few times per week
- ☐ Few times per month
- ☐ Never
- ☐ Other: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Phone #: _____

Pharmacy Street Address: _____

Pharmacy City, Zip Code _____

DEMOGRAPHIC INFORMATION

Preferred language: _____

Race: _____

Ethnic Group: _____

