PATIENT INFORMATION

Case # _____ SS#_____ Date_____

Name_____ Sex ____ Age _____ BirthDate _____

Marital Status Single____ Married_____ Divorced_____ Widowed_____

Address _____ City _____ State_____ Zip _____

Telephone # _____ Cell # _____ Email _____

If minor, name of parent or guardian_____

Name and address of person financially responsible, if different from parent:

_____

Pharmacy name, address and tel. #_____

Referred By _____ Family Physician_____

Race: ( ) White
( ) Black or African American
( ) Asian
( ) Native American or Alaskan
( ) Native Hawaiian or other Pacific Islander
( ) Unknown
( ) Refuse

Ethnicity: ( ) Hispanic
( ) Non-Hispanic
( ) Unknown
( ) Refuse

Patient's Occupation: _____ Is Visit Job Related? _____

Employed By_____ Business Phone _____

Spouse's Name _____ Spouse's Occupation _____

Employed By _____ Business Phone _____

INSURANCE INFORMATION

Primary Insurance Co. Name:_____ **ID#**_____

Name of Subscriber: _____ BirthDate of Subscriber: _____ SS#: _____

Relationship to Patient: _____

Secondary Insurance Co. Name: _____ **ID#** _____

Name of Subscriber: _____ BirthDate of Subscriber: _____ SS#:_____

Relationship to Patient: _____

PATIENT'S NAME_____ **DATE**_____

SECTION A History of Skin Problem

Chief complaint or nature of problem:_____.

How long has this condition been present? 1-6 days, 1-3 wks, 1-11 months, more than one year. (circle one)

Have you recently been on , or are you currently on treatment for this condition?
Yes____ No____ List treatments _____
_____

Has this treatment been effective? Very___Partly___Only slightly___ Not at all___

If there are any additional skin problems which you want to discuss
(time permitting – you may be asked to return at another time if the problem(s) are not urgent), please list them here_____

SECTION B Past Medical History

Have you ever been treated for any of the following (Please circle appropriate answers)

			List treatment(s)
Arthritis	Y	N	_____
Duodenal or peptic ulcer (circle)	Y	N	_____
Chronic intestinal disease	Y	N	_____
Tuberculosis	Y	N	_____
Asthma	Y	N	_____
Hay fever/seasonal allergies	Y	N	_____
Heart disease	Y	N	_____
Kidney disease	Y	N	_____
Thyroid disease	Y	N	_____
Neurological disease	Y	N	_____
Depression	Y	N	_____
High blood pressure	Y	N	_____
Liver disease	Y	N	_____
Diabetes	Y	N	_____
High cholesterol	Y	N	_____
Triglycerides	Y	N	_____
Cancer (excluding skin cancer)	Y	N	_____
Melanoma	Y	N	_____
Other skin cancer	Y	N	_____
Eczema	Y	N	_____
Psoriasis	Y	N	_____
Hives	Y	N	_____

PATIENT'S NAME_____**DATE**_____

Other specific skin disease(s) Y N _____
Which one(s)?_____
Any other significant medical condition(s) Y N
Which one(s)?_____
Do you have a pacemaker or internal difibrillator? Y N
Have you ever been treated with X-ray therapy or other forms of radiation? Y N
Have you ever developed an overgrown or keloid scar? Y N
Are you currently taking any medicine which makes you bleed easily (eg., aspirin, coumadin, etc.)? Y N
If so, list_____
Have you recently visited an emergency room or doctor's office for a medical emergency or a serious injury? If so, why?_____ Y N
_____
Have you ever been hospitalized? Y N
If so, why?_____
Have you ever had an operation? Y N
If so, what type?_____
To your knowledge, have you been exposed to any infectious disease in recent weeks? Y N
If so, which one? _____.
Do you have allergies to any medication? Y N
If so, list_____
_____
Are there any medicines you have been told to avoid? If so, list_____ Y N

Please list all the medicines you are currently taking (use back if necessary):

Medicine	Dose (mg)	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT'S NAME_____**DATE**_____

SECTION C Family History

To your knowledge, do any of your blood relatives have a history of the following (circle appropriate answers)

			If yes, which relatives
Psoriasis	Y	N	_____
Eczema	Y	N	_____
Hives	Y	N	_____
Asthma	Y	N	_____
Hay fever/ seasonal allergies	Y	N	_____
Lipomas	Y	N	_____
Cysts	Y	N	_____
Keloids (overgrown scars)	Y	N	_____
Melanoma	Y	N	_____
Other skin cancers	Y	N	_____

SECTION D Social History

Have you ever smoked?	Y	N
Have you ever used other tobacco products?	Y	N

If yes to either question, are you: (circle one)
An every day smoker/user
A some days smoker/user
A former smoker/user

For women: Are you pregnant? Y N Not Sure

No. of persons in household____

Hobbies_____ Sports in which you participate_____

Pets_____ Recent Foreign Travel Y___ N____ Where?_____