PATIENT INFORMATION

SSN _____ TODAY'S DATE: _____

NAME: _____ SEX: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: HOME: _____ CELL: _____ EMAIL: _____

IF MINOR, NAME OF PARENT OR GUARDIAN: _____

NAME OF PERSON FINANCIALLY RESPONSIBLE: _____

ADDRESS OF PERSON FINANCIALLY RESPONSIBLE: _____

REFERRED BY: _____ PRIMARY CARE PHYSICIAN: _____

PHARMACY NAME: _____ **PHONE:** _____

PHARMACY ADDRESS: _____

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: _____

SPOUSE'S EMPLOYER: _____ BUSINESS PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ ID#: _____

NAME OF **SUBSCRIBER**: _____ DOB: _____

SUBSCRIBER SSN: _____ RELATION TO PATIENT: _____

SECONDARY INSURANCE NAME: _____ ID#: _____

NAME OF SUBSCRIBER: _____ DOB: _____

SUBSCRIBER SSN: _____ RELATION TO PATIENT: _____

PATIENT'S NAME: _____ **TODAY'S DATE:** _____

SECTION A: HISTORY OF SKIN PROBLEM

Chief complaint / Nature of problem: _____

How long has this condition been present?: 1 - 6 days 1 – 3 weeks 1 – 11 months more than one year

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 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	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: ______________________________ **TODAY'S DATE:** ______________

Other specific skin disease(s): Y N ____________________

Any other significant medical condition(s): Y N ____________________

Do you have a pacemaker or internal defibrillator: Y N

Have you ever been treated w/ 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 (e.g.: aspirin, coumadin, etc) Y N ____________________

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 ____________________

Have you ever had an operation: Y N ____________________

Have you recently been exposed to any infectious disease: Y N ____________________

DO YOU HAVE ALLERGIES TO ANY MEDICATION(S): Y N ____________________

____

Are there any medicines you have been told to avoid: Y N ____________________

Please list all current medications (use back of this sheet, if necessary:

Medication Name	Dose (mg)	Frequency

PATIENT'S NAME: _____ **TODAY'S DATE:** _____

SECTION C: FAMILY HISTORY

To your knowledge, do any of your blood relatives have a history of the following:

			IF YES, WHICH RELATIVE(S)
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 TOBACCO PRODUCTS Y N

IF YOU ANSWERED "YES" TO EITHER QUESTION ABOVE:

ARE YOU AN EVERY DAY SMOKER / TOBACCO PRODUCT USER Y N

A SOME DAYS SMOKER / TOBACCO PRODUCT USER Y N

A FORMER SMOKER / TOBACCO PRODUCT USER Y N

ARE YOU PREGNANT Y N NOT SURE

NUMBER OF PERSONS IN HOUSEHOLD: _____

HOBBIES _____

SPORTS IN WHICH YOU PARTICIPATE _____

PETS Y N _____

RECENT FOREIGN TRAVEL Y N _____