Patient Information

Name: ____ Today's Date: _______________________

Date of Birth:_____/_____/_______ Gender: ________ Marital Status: ________

Home Phone Number: _________________________ Cell Phone Number: _________________________

Mailing Address: ____

City: _________________________________ State: _________________ Zip Code: _______________

Email (Please print clearly): ____

Legal Guardian Name: _______________________ Legal Guardian DOB: ______________________

Legal Guardian Phone: _______________

Emergency Contact: _______________________________ Emergency Contact Phone: ________________

Employer Name___________________________ Employer Phone number__________________________

Primary Insurance: ______________________________ Insurance ID Number: __________________

Policy Holder Name:_____________________________ Policy Holder's Date of Birth____________________

Relationship to Policy Holder: _______________

Primary Care Physician (PCP)	Referring Physician	Preferred Pharmacy
Name: ___________________	Name: ___________________	Name: ___________________
Phone Number: ___________	Phone Number: ___________	Phone Number: ___________
City or Zip Code: __________	City or Zip Code: __________	City / Zip Code: __________

Did they refer you? ☐ Yes ☐ No

Past Medical History

Please check if you have been diagnosed with:

☐ Anxiety	☐ Diabetes	☐ Leukemia
☐ Arthritis	☐ End Stage Renal Disease	☐ Lung Cancer
☐ Asthma	☐ Hepatitis	☐ Lymphoma
☐ Breast Cancer	☐ HIV/AIDS	☐ Radiation Treatment
☐ Colon Cancer	☐ High Cholesterol	☐ Seizures
☐ COPD	☐ Hyperthyroidism	☐ Other: ______________
☐ Depression	☐ Hypothyroidism	____________________
		☐ NONE

Past Surgical History

Please list any major surgical procedures:

____

____

Skin Disease History

Please check if you have been diagnosed with:

- ☐ Acitinic Kertoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Eczema
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Squamous Cell Skin Cancer

Do you have a family history of Melanoma?

- ☐ No
- ☐ Yes. If so, which relative(s)? ______________________

Do you tan in a tanning salon?

- ☐ No
- ☐ Yes

Do you wear sunscreen?

- ☐ No
- ☐ Yes. If so, what SPF? ______________________

Allergies

Are you allergic to: LIDOCAINE EPINEHPHRINE ADHESIVES ANTIBIOTICS

List all known Allergies and Reactions:

____

☐ No Known Allergies

Medications

Please list all current medications:

____

____

Have you had a Pneumonia Vaccine, within the past year? ☐ No ☐ Yes

Have you had an Influenza Vaccine, within the past year? ☐ No ☐ Yes

Family History

Please indicate only 1st degree relatives (mother, father, brother, sister, children)

☐ Skin Cancer ____________________ ☐ Breast Cancer ____________________ ☐ Colon Cancer ________________

☐ Bleeding Disorders ________________ Other____

Patient Information

Social History

- **Smoking Status:**

  ☐ Current Smoker
  ☐ Former Smoker
  ☐ Never Smoker

- **Alcohol Drinking Habits**

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

- How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? ______________________