NJ Certified Dermatology PC

PATIENT INFORMATION

PATIENT'S NAME: ____ Today's Date:____________________

Date of Birth: ____/____/________ (mm/dd/yyyy)

Gender: □ Male □ Female
Language: □ English □ Spanish □ Other: ______________
Marital Status: □ Single □ Married □ Divorced □ Widow □ Separated

RACE: Please Check
□ White
□ American Indian or Alaska-Native
□ Asian
□ Black or African American
□ Native-Hawaiian or other Pacific Islander
□ Other

ETHNICITY: Please Check
□ Hispanic or Latino
□ Non-Hispanic or Latino

PHONE NUMBERS:
Home___________________________ Cell ___________________________ Work ________________________
Preferred phone: please check
□ Home □ Cell □ Work

Email: ____

Is it OK to leave a detailed message?
□ YES or □ NO

PRIMARY CARE PHYSICIANS INFORMATION:

Name:____

Address: ____

____

Phone #: _____________________________ Fax #: ________________________

IS YOUR REFERRING PHYSICIAN THE SAME AS YOUR PRIMARY CARE PHYSICIAN? □ YES OR □ NO

IF THIS IS YOUR FIRST VISIT ONLY: DOES YOUR INSURANCE REQUIRE A REFERRAL? □ YES OR □ NO

PHARMACY INFORMATION:
Name: ___________________________________
Street/City:_______________________________
State: ______________, Zip Code _____________

PAST MEDICAL HISTORY
Please **check** any of the following medical conditions that you currently have:

□ Anxiety
□ Arthritis
□ Asthma
□ Atrial Fibrillation (Irregular heartbeat)
□ BPH (benign enlarged prostate)
□ Bone Marrow Transplantation
□ Breast Cancer
□ Colon Cancer
□ COPD
□ Coronary Artery Disease
□ Depression
□ Diabetes
□ End Stage Renal Disease
□ GERD
□ Hearing Loss
□ Hepatitis
□ Hypertension
□ HIV/Aids
□ Hypercholesterolemia (high cholesterol)
□ Hyperthyroidism
□ Hypothyroidism
□ Leukemia
□ Prostate Cancer
□ Radiation Treatment
□ Seizures
□ Stroke
□ Other _______________________________

SURGICAL HISTORY:
Please list any surgeries you have had in the past? If so please list:
____

____

SKIN DISEASE HISTORY
Please **check** if you have had any of the following skin conditions:

□ Acne
□ Actinic Keratosis
□ Asthma
□ Basal Cell Carcinoma
□ Blistering Sunburn
□ Dry Skin
□ Eczema
□ Other ____________________________
□ Flaky or itchy scalp
□ Hay fever/Allergies
□ Melanoma
□ Poison Ivy
□ Precancerous Moles
□ Psoriasis
□ Squamous Cell Skin Cancer

Do you wear Sunscreen?
(Please check) □ YES or □ NO

If yes, what SPF? ______________

Do you tan in tanning salon?
(Please check) □ YES or □ NO

FAMILY HISTORY:
Do you have a family history of Melanoma?
(Please check) □ YES or □ NO
If yes, which relative?

□ Mother	□ Father	□ Sister
□ Brother	□ Daughter	□ Son
□ Uncle	□ Aunt	□ Nephew
□ Niece	□ Grandmother	□ Grandfather

MEDICATIONS: (Please list- if you have a list with you, document, see list, and give to nurse in exam room)
____
____
____

ALLERGIES:
____
____

Social History:
FEMALES ONLY: Last menstrual period (LMP): ________________ Menopausal: □ Yes or □ No

SMOKING HISTORY: (Please Check)

□ Current every day smoker □ Former smoker □ Smoker: current status unknown
□ Current someday smoker □ Never smoker □ Unknown if ever smoked

Please check Yes or No if you have any of the following:

Pacemaker □ YES □ NO
Defibrillator □ YES □ NO
Premedication prior to procedure □ YES □ NO
Allergy to adhesive □ YES □ NO
Blood thinners □ YES □ NO
Pregnancy or planning a pregnancy □ YES □ NO □ N/A
Allergy to lidocaine □ YES □ NO
Allergy to Latex □ YES □ NO
Rapid heartbeat with epinephrine □ YES □ NO
Melanoma History □ YES □ NO
IF yes:
Date:___________ Lymph node mapping _____________
Immunosuppressant □ YES □ NO
Problems with bleeding □ YES □ NO
Artificial joints within past two years □ YES □ NO
Artificial heart valve □ YES □ NO
Allergy to topical antibiotic ointment □ YES □ NO

Patient is NOT their own POA (Power of Attorney)
□ YES □ NO

REASON FOR YOUR VISIT TODAY:
____
____
____