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THE DERM INSTITUTE

PATIENT INFORMATION AND MEDICAL HISTORY FORM

PATIENT DEMOGRAPHICS

Preferred Called Name: _____ Age: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Social Security: _____

CONTACT

Home: _____ Work: _____ Cell: _____

May we leave a detailed message? ☐ Yes ☐ No IF YES, please circle preferred number.

Email: _____

May we email you for appointment reminders, confidential results, promos, etc? ☐ Yes ☐ No

Circle preferred appointment reminder: Email TextMessage Phone(h) Phone(w) Phone (c)

ADDRESS

Address: _____

City: _____ State: _____ Zip: _____

EMPLOYMENT

Employer: _____ Occupation: _____

EMERGENCY CONTACT

Last Name: _____ First Name: _____

Phone Number: _____ Relationship to Patient: _____

FINANCIALLY RESPONSIBLE PARTY (Complete if NOT SELF/Patient is a MINOR/NOT the main policy holder.)

Last Name: _____ First Name: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security: _____

Address: _____ Phone: _____

PRIMARY PHYSICIAN

Physician Name: _____ Physician Phone: _____

Physician Address: _____

PREFERRED PHARMACY

Pharmacy Name: _____ Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

REFERRAL

How did you hear about us? (If physician/friend, please list name)

_____

PATIENT MEDICAL HISTORY

Reason for Today's Visit: _____

KEY PAST MEDICAL HISTORY (please check all that apply)

☐Anxiety ☐ Diabetes ☐Thyroid Disease: Hyper/Hypo

☐Arthritis ☐ Hepatitis, Type: _____ ☐ Radiation Treatment or History

☐Asthma ☐ Hypertension (high blood pressure) ☐ Seizures

☐Cancer(type): _____ ☐ HIV+/AIDS ☐ NONE

OTHER (please check all that apply)

☐Reaction to Local Anesthetic ☐ Keloid Scarring ☐ Cold Sores/Oral Herpes

☐Blood Clots ☐ Stomach Ulcer History ☐ Organ Transplant: _____

Other Health Conditions: _____

Current Weight: _____ Current Height: _____ Most Recent Blood Pressure: _____

PAST SURGERIES: _____

SKIN CONDITION HISTORY (please check all that apply)

☐Actinic Keratosis ☐Hayfever/Allergies ☐ Squamous Cell Skin Cancer

☐Basal Cell Skin Cancer ☐Melanoma ☐ NONE

☐Blistering Sunburns ☐Precancerous Moles ☐Other: _____

GENERAL SKIN QUESTIONS (please circle all that apply)

Wear Sunscreen, SPF: _____ History of Tanning Salon Use: Yes No CURRENT

Has a Relative Had Melanoma? ☐ Yes ☐ No If yes, which relative(s): _____

CAUTIONS

☐Difficulty Stopping Bleeding ☐Artificial Joint: _____☐ Pacemaker/Defibrillator

☐Antibiotic for Dental Procedures ☐ Artificial Heart Valve ☐ **(WOMEN)** Pregnant, Trying, Nursing

☐ **Fainting with Procedures**

ALLERGIES

Medication Allergies (please list): _____ Latex Allergy: ☐ Yes ☐ No

MEDICATIONS

Prescription medications (please list): _____

Over-the-counter medications, herbals, vitamins (please list): _____

SOCIAL HISTORY (please check all that apply)

☐Currently Smokes ☐ Smoked in the Past ☐ Drug Use: _____

Patient Signature: _____ Date: _____

Patient Name (Print): _____

I certify I have completed this form in its entirety, and the above is true and correct.

(CLINIC USE:REVIEWED_____)