Annie Chiu, M.D.
THE DERM INSTITUTE

PATIENT INFORMATION AND MEDICAL HISTORY FORM

PATIENT DEMOGRAPHICS

Preferred Called Name: _____ Age: _____ Date of Birth: _____

Last Name: _____ First Name: _____ MI: _____

CONTACT INFORMATION

Phone: _____ Cell: _____ Txt Msg OK: ☐ Yes ☐ No

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

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)

Last Name: _____ First Name: _____

Relationship to patient: _____ Date of Birth: _____

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 ☐ Cancer (type): _____ ☐ Hyperthyroid / Hypothyroid

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

☐ Asthma ☐ Hypertension (high blood pressure) ☐ Seizures

☐ Diabetes ☐ 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: _____

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 check 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 (please check all that apply)

☐ Difficulty Stopping Bleeding ☐ Pacemaker / Defibrillator ☐ Metal Implants/Screws

☐ Antibiotic for Dental Procedures ☐ Artificial Joint _____ ☐ Artificial Heart Valve

☐ **Fainting with Procedures** ☐ **(WOMEN)** Pregnant, Trying, Nursing

ALLERGIES

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

MEDICATIONS

Prescription Medications (please list): _____

Over-the-counter medications (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 _____)