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
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Cancer (type): _____
- ☐ Hepatitis, Type: _____
- ☐ Hypertension (high blood pressure)
- ☐ HIV+ / AIDS
- ☐ Hyperthyroid / Hypothyroid
- ☐ Radiation Treatment or History
- ☐ Seizures
- ☐ NONE

OTHER (please check all that apply)

- ☐ Reaction to Local Anesthetic
- ☐ Blood Clots
- ☐ Keloid Scarring
- ☐ Stomach Ulcer History
- ☐ Cold Sores / Oral Herpes
- ☐ Organ Transplant _____

Other Health Conditions: _____

PAST SURGERIES: _____

SKIN CONDITION HISTORY (please check all that apply)

- ☐ Actinic Keratosis
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Hayfever/Allergies
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ 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
- ☐ Antibiotic for Dental Procedures
- ☐ **Fainting with Procedures**
- ☐ Pacemaker / Defibrillator
- ☐ Artificial Joint _____
- ☐ **(WOMEN)** Pregnant, Trying, Nursing
- ☐ Metal Implants/Screws
- ☐ Artificial Heart Valve

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 _____)