

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 State : \_\_\_\_\_ Zip: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
 Marital Status: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Emergency Number: \_\_\_\_\_  
 How did you hear about our practice?: \_\_\_\_\_  
 Allergies to Medications: \_\_\_\_\_  
 Current Medications: \_\_\_\_\_

Currently Using	Yes	No	Yes	No	Yes	No
Aspirin / Motrin / Advil.....	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills.....	<input type="checkbox"/>	Are you pregnant?.....	<input type="checkbox"/>
Coumadin / Plavix.....	<input type="checkbox"/>	<input type="checkbox"/>	Are you breastfeeding.....	<input type="checkbox"/>	Plan on becoming pregnant?..	<input type="checkbox"/>

**Skin Related Review of Systems (Current or past problems)**

	Yes	No	Yes	No	Yes	No
Acne.....	<input type="checkbox"/>	<input type="checkbox"/>	Eczema (Atopic Dermatitis)..	<input type="checkbox"/>	Psoriasis.....	<input type="checkbox"/>
Precancerous Lesions (AKs).....	<input type="checkbox"/>	<input type="checkbox"/>	Efudex used for precancers..	<input type="checkbox"/>	Liquid Nitrogen for precancers.	<input type="checkbox"/>
Aldara used for precancers.....	<input type="checkbox"/>	<input type="checkbox"/>	Other Skin Problems: _____			
Skin Cancers (non-melanoma)....	<input type="checkbox"/>	<input type="checkbox"/>	Locations & Type: _____			
Melanoma.....	<input type="checkbox"/>	<input type="checkbox"/>	Locations: _____			

**Review of Systems (Current or past problems)**

	Yes	No	Yes	No	Yes	No
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever (Allergic Rhinitis).	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>
Blood / Bleeding Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes.....	<input type="checkbox"/>	Heart Disease.....	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS.....	<input type="checkbox"/>	Kidney Disease.....	<input type="checkbox"/>
Liver Disease or Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease.....	<input type="checkbox"/>	Lupus.....	<input type="checkbox"/>
Psychological Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	Cancers (non-skin).....	<input type="checkbox"/>	Locations: _____	
Thyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Other Health Problems: _____			

**Family History (Conditions that have occurred in your immediate family - parents, siblings, children)**

	Yes	No	Yes	No	Yes	No
Eczema (Atopic Dermatitis).....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever (Allergic Rhinitis).	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>
Lupus.....	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis.....	<input type="checkbox"/>		
Skin Cancer (non-melanoma).....	<input type="checkbox"/>	<input type="checkbox"/>	Melanoma.....	<input type="checkbox"/>	Cancer (non-skin).....	<input type="checkbox"/>
Live alone?.....	<input type="checkbox"/>	<input type="checkbox"/>	Drink alcohol?.....	<input type="checkbox"/>	Frequency: _____	
Use recreational drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>	Smoke?.....	<input type="checkbox"/>	Frequency: _____	
Have a pacemaker / defibrillator?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Need antibiotics prior to surgical / dental procedures?.....	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_