

**ADULT & PEDIATRIC DERMATOLOGY SPECIALISTS, P.C.**

**Patient Information**

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Sex  M  F Marital Status  S  M  D  W Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_

Has any member of your immediadte family been treated by our physician(s) before?  Yes  No

Please give name \_\_\_\_\_

Primary Care MD \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_\_

Employer: Name \_\_\_\_\_

Address \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

**Insurance Information: Primary Insurance**

Insurance Name \_\_\_\_\_ Subscriber ID \_\_\_\_\_

**Insurance Information: Secondary Insurance**

Insurance Name \_\_\_\_\_ Subscriber ID \_\_\_\_\_

**Patient (or Guardian): Read, sign and date section**

**Release of Information:** I authorize Adult & Pediatric Dermatology Specialists, P.C. to release any medical information necessary to process insurance claims to billing service and to the insurance companies and/or case management organizations that are providing my health insurance.

**Assignment of Benefits:** I authorize payment of all medical benefits directly to Adult & Pediatric Dermatology Specialists, P.C.

**Patient's Responsibility for Payment:** I understand that I am responsible for payment for services that are not covered by my insurance plan.

I acknowledge the opportunity to review Adult & Pediatric Dermatology Specialists, P.C. Notice of Privacy Practices.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDS): 1. \_\_\_\_\_

2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**MEDICATION ALLERGIES:** \_\_\_\_\_ None  Do you take aspirin daily? Yes \_\_\_ No \_\_\_

NAME OF MEDICATION	TYPE OF REACTION
_____	rash ___ difficulty breathing ___ stomach pain/vomiting ___ other: _____
_____	rash ___ difficulty breathing ___ stomach pain/vomiting ___ other: _____
_____	rash ___ difficulty breathing ___ stomach pain/vomiting ___ other: _____

DO YOU ROUTINELY REQUIRE ANTIBIOTICS PRIOR TO DENTAL/SURGICAL PROCEDURES DUE TO A HEART MURMUR, ARTIFICIAL HEART VALVE, ARTIFICIAL JOINT, ETC.? YES/NO

DO YOU FORM LARGE SCARS (**KELOIDS**) WHEN INJURED? \_\_\_YES \_\_\_NO

What skin problem do you wish the doctor to examine? \_\_\_\_\_

CHECK ANY THAT APPLY: \_\_\_\_\_

- \_\_\_ RASH \_\_\_\_\_
- \_\_\_ ITCH \_\_\_\_\_
- \_\_\_ PIMPLES/ACNE \_\_\_\_\_
- \_\_\_ GROWTHS \_\_\_\_\_
- \_\_\_ MOLES \_\_\_\_\_
- \_\_\_ PAIN \_\_\_\_\_
- \_\_\_ OTHER \_\_\_\_\_

What location on the body? \_\_\_\_\_

How long has the problem been present? \_\_\_days, \_\_\_weeks, \_\_\_months\_\_\_years The problem is \_\_\_constant \_\_\_comes and goes

What have you done previously for this problem? \_\_\_\_\_

Medications for this problem \_\_\_\_\_ What makes symptom better? \_\_\_\_\_  
Worse? \_\_\_\_\_

**MEDICAL PROBLEMS/ HOSPITALIZATIONS/SURGERIES**      None       DATE

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

FOR WOMEN ONLY: A. Are you pregnant or currently planning a pregnancy? Yes No

B. Are you currently nursing? Yes No

**FAMILY MEDICAL HISTORY (PLEASE ADD ANY OTHERS NOT LISTED)**      None

CONDITIONS/PROBLEMS      Family Members affected and exact nature of problems

- \_\_\_ Melanoma \_\_\_\_\_
- \_\_\_ Non Melanoma Skin Cancer \_\_\_\_\_
- \_\_\_ Blistering Disorder \_\_\_\_\_
- \_\_\_ Auto-Immune Disorder \_\_\_\_\_
- \_\_\_ Psoriasis \_\_\_\_\_

**SOCIAL HISTORY/HABITS**

Occupation \_\_\_\_\_ Retired \_\_\_ Alcohol Use: \_\_\_ No \_\_\_ Yes (drinks/week): \_\_\_\_\_

Smoker: \_\_\_ packs/day Non-smoker \_\_\_ Quit smoking in \_\_\_ Smokeless Tobacco: \_\_\_\_\_

I have traveled outside of the United States in the past three months: \_\_\_\_\_

Cont'd on other side

**REVIEW OF SYSTEMS: Please mark the symptoms you've been having recently.**

**Constitutional**

- weight gain/loss
- loss of appetite
- fever/chills
- weakness
- night sweats

**Skin**

- rash
- lumps
- hives
- dry/sensitive skin
- suspicious moles/lesions
- jaundice
- acne
- itching
- hair loss

**Musculoskeletal**

- Joint stiffness
- leg cramps
- joint pain
- joint swelling
- back pain
- neck pain
- muscle aches

**Allergy**

- runny nose
- scratchy throat
- itchy eyes
- sinus congestion
- sneezing

**Cardiology**

- chest pain
  - palpitations
- Ear/Nose/Throat**
- congestion
  - nosebleed
  - change in voice
  - sore throat
  - difficulty swallowing

**Endocrine**

- excessive sweating
- excessive thirst
- excessive urination
- heat intolerance
- cold intolerance

**Blood/Lymph**

- swollen glands
- fatigue
- varicose veins
- easy bruising
- leg swelling

**Psychology**

- depression
- high stress level
- suicidal thinking
- eating disorder
- mental/physical abuse
- mood swings
- obsessive-compulsive tendencies

**Respiratory**

- shortness of breath
- chest tightness
- cough
- wheezing
- congestion

**Gastroenterology**

- nausea
- vomiting
- heartburn
- abdominal pain
- change in bowel habits

**Eyes**

- decreased vision
- eye irritation
- eye drainage
- blurry vision

**Neurology**

- headache
- tingling/numbness
- seizures
- dizziness

**Urology**

- difficulty urinating
- blood in urine
- leaking urine

\*History of present illness and expanded review of systems reviewed with patient by provider.

WE HEREBY ADVISE YOU: IN ORDER TO PREVENT THE OCCURRENCE OF UNDETECTED SKIN CANCER, YOU MUST HAVE A YEARLY SKIN EVALUATION BY A DERMATOLOGIST.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date