

**General Information**

| First Name | Middle Name | Last Name |
| --- | --- | --- |
| DOB | SSN | Male Female Other |
| Weight | Height | Gender Identity: |
| Primary care Physician: |
| How did you hear about us? |

**Contact Information**

| Address | City | State | Zip |
| --- | --- | --- | --- |
| Mobile Phone | Home Phone | Email |
| Other Phone | Preferred Communication |
| Employment Status | Employer |

**Responsible Person**

| First Name | Last Name | Relationship to Patient |
| --- | --- | --- |
| Address | City | State | Zip |
| Mobile Phone | Home Phone | Email |

Complete this section if the patient is NOT the primary policyholder or if the patient is a minor.

**Emergency Contact**

* Check here if emergency contact name and address is same as responsible person above and skip section below.

| First Name | Last Name | Relationship to Patient |
| --- | --- | --- |
| Address | City | State | Zip |
| Mobile Phone | Home Phone | Email |

**Favorite Pharmacy**

| Name | Phone |
| --- | --- |
| Address | City | State | Zip |

**Allergies**

| * No Allergies
 | * Latex
 | * Penicillin
 |
| --- | --- | --- |
| * Other:
 |

**Medications**

Please list all medications you are taking below including vitamins, aspiring, supplements, herbals, over-the-counter.

|  |
| --- |
|  |
|  |

**Skin Conditions**

| * No medical history
 | * Acne
 | * Actinic Keratosis / AKs
 |
| --- | --- | --- |
| * Basal Cell Carcinoma
 | * Dysplastic Nevus/moles
 | * Eczema/atopic dermatitis
 |
| * Keloids
 | * Malignant Melanoma
 | * Psoriasis
 |
| * Squamous Cell Skin Cancer
 |  |  |
| * Other:
 |

Please select if you have any of the medical conditions below. If a condition is not listed, please write in the bottom.

**Medical Conditions**

Please select if you have any of the medical conditions below. If a condition is not listed, please write in the bottom.

| * No medical history
 | * Anxiety/Depression
 | * Arthritis
 |
| --- | --- | --- |
| * Asthma
 | * Blood clotting disorder
 | * Crohn’s disease
 |
| * Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Diabetes
 | * HIV Positive
 |
| * Heart Attack
 | * Heart disease
 | * Heart failure
 |
| * Hepatitis B
 | * Hepatitis C
 | * High Blood Pressure
 |
| * Kidney Disease
 | * Liver disease
 | * Lupus
 |
| * Mental Disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Migraine
 | * Seasonal Allergy
 |
| * Seizure
 | * Stomach Ulcer
 | * Stroke
 |
| * Thyroid Disease
 | * Tuberculosis
 | * Ulcerative Colitis
 |
| * Other:
 |

**Past Surgeries**

| * None
 | * Bone marrow transplant
 | * Heart valve replaced
 |
| --- | --- | --- |
| * Implant internal cardiac defibrillator
 | * Joint replaced
 | * Solid organ transplant
 |
| * Implant cardiac pacemaker
 | * Mohs
 |  |
| * Other:
 |

**Family History**

If yes, please include which relative.

| * Atopic Dermatitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * BCC \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * SCC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| --- | --- | --- |
| * Skin Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Psoriasis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Malignant Melanoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Other:
 |

| **Obstetric History** | * Not Applicable
 | * Pregnant
 | * Mother Currently Breastfeeding
 |
| --- | --- | --- | --- |
| **History of Exposure** | Excessive Sun exposure?* Yes
* No
 | Skin tanning/ tanning bed use?* Yes
* No
 | Exposure to radiation?* Yes
* No
 | Sunscreen Use? * Yes
* No
 |
| **Smoking Status** | * Non-Smoker
 | * Smoker
 | * Ex-Smoker
 |
| **Alcohol Use** | * Social drinker
 | * Heavy drinker
 | * Non-drinker
 |
| **Marital Status** | * Married
 | * Single
 | * Divorced
 | * Widowed
 |
| **Immunizations** | Have you had your flu - Influenza vaccine this year?* Yes
* No
 | If over age 65, have you had your pneumococcal vaccine? * Yes
* No
 |
| **Advanced Directive** | If over age 65, do you have an advanced care plan (advance directive)?* Yes
* No
 |