

**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 | | | | |