Patient Name: ______________________ **DOB:** ____ / ____ / ____

Address: ______________________ **City:** ______________ **State:** ______ **Zip:** ______

Cell: ______________________ **Email:** ______________________

Did you receive a new or updated Insurance card this year? ☐ YES ☐ NO **Sex:** ☐ Male ☐ Female

Name of Insurance ______________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouses Name and contact info: ______________________ **DOB** ______________

By Law, medical information is confidential unless written permission is given. Do you want your medical information released to anyone other than yourself? ☐ YES ☐ NO **If yes, please print their name and phone #**

____

Pharmacy (name/town/phone #): ______________________

Occupation or Previous occupation if retired: ______________________

Primary Care Physician: ______________________ **Referring Physician:** ______________________

Past Medical History: Heart Disease, Cancer, Bowel Disease, Etc. ______________________

____

Past Surgical History: ______________________

Skin Disease History: (please circle all that apply)

- Acne
- Actinic keratosis
- Asthma
- Basal cell skin cancer
- Blistering sunburns
- Dry skin
- Eczema
- Flaking/itchy scalp
- Hay fever/allergies
- Melanoma
- Poison Ivy
- Precancerous moles
- Psoriasis
- Squamous cell skin cancer

Prescription Medications: (please list Medication and dosage) ______________________

____

Allergies: (Please list all known allergies and reactions) ______________________

____

Do you wear Sunscreen? ☐ YES ☐ NO

If yes, what SPF: ______________________

If you are over the age of 65, have you ever had the pneumonia vaccination? ☐ YES ☐ NO

Did you receive the Flu Vaccination this flu season Or last?

☐ YES ☐ NO If no, ☐ Refused ☐ Allergy to Vaccine ☐ Medical reason

Do you have a personal history of Malignant Melanoma?

YES ☐ NO

If yes, location, size and year of diagnosis ______________________

Do you have a family history of Malignant Melanoma

☐ YES ☐ NO

If yes, which relative (s) ______________________

Social History:

Smoking status: ☐ Current daily smoker ☐ Current occasional smoker ☐ Former smoker ☐ Never a smoker

If you are a current smoker, Atlantic Shore Dermatology counsels you that smoking causes serious risks to your health and we recommend a smoking cessation plan.

Signature: ______________________ **Date:** ______________________