Patient Name: _____ **DOB:** _____ / _____ / _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ **Email:** _____

Did you receive a new or updated Insurance card this year? ☐ YES ☐ NO

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:

_____

Past Medical History: (please circle all that apply)

• Anxiety	• Crohn's or Ulcerative Colitis	• Inflammatory Bowel Disease
• Arthritis	• Depression	• Hyperthyroidism
• Asthma	• Diabetes	• Hypothyroidism
• Atrial fibrillation	• End stage renal disease	• Leukemia
• Bone marrow transplant	• GERD	• Lung cancer
• BPH	• Hearing loss	• Lymphoma
• Breast cancer	• Hepatitis	• Prostate cancer
• Colon cancer	• Hypertension	• Radiation treatment
• COPD	• HIV / AIDS	• Seizures
• Coronary artery disease	• Hypercholesterolemia	• Stroke

Other:

Past Surgical History: (please circle all that apply)

• Appendix removed	• Kidney biopsy
• Bladder removed	• Kidney removed (right, left)
• Breast Biopsy (right, left, bilateral)	• Kidney stone removal
• Lumpectomy (right, left, bilateral)	• Kidney transplant
• Mastectomy (right, left, bilateral)	• Kidney removed
• Bowel Resection (Colectomy)	• Hepatectomy
• Gallbladder removed	• Liver transplant
• Coronary artery bypass	• Liver shunt
• Angioplasty (PTCA)	• Ovaries removed: (endometriosis, cancer, cyst)
• Biological valve replacement	• Pancreas removed
• Mechanical valve replacement	• Prostate removed: (cancer, TURP)
• Heart transplant	• Rectal resection
• Hip replacement (right, left, bilateral)	• Spleen removed
• Knee replacement (right, left, bilateral)	• Testicles removed (right, left, bilateral)
	• Hysterectomy (fibroids, uterine cancer, cervical cancer)

Other:

Skin Disease History: (please circle all that apply)

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

Other:

DO YOU WEAR SUNSCREEN? ☐ YES ☐ NO
If yes, what SPF: _____

DO YOU TAN IN A TANNING SALON?
☐ YES ☐ NO

Did you receive the Flu vaccination during 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): _____

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

MEDICATIONS (please list all current medications and dosage): ☐ NO MEDICATIONS

_____ _____

_____ _____

DRUG ALLERGIES (please list all known allergies and reactions): ☐ NO KNOWN DRUG ALLERGIES

_____ _____

SOCIAL HISTORY:
Smoking status: ☐ Current daily smoker ☐ Current occasional smoker ☐ Former smoker ☐ Never 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.

Alcohol use: ☐ None ☐ < 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

On any occasion have you had more than 5 drinks on more than 2 occasions within the past 12 months?
☐ yes ☐ no
If yes, Atlantic Shore Dermatology counsels you that unhealthy alcohol use causes serious risks to your health.

ALERTS: (please circle all that apply)		
• Allergy to adhesive • Allergy to latex • Allergy to lidocaine • Artificial valve replacement • Allergy to antibiotic ointment	• Artificial joint replacement • Blood thinners • Defibrillator • Keloid scarring • HIV	• Hep C • MRSA • Pacemaker • Require antibiotics prior to procedure

ARE YOU PREGNANT OR CURRENTLY TRYING TO GET PREGNANT? ☐ YES ☐ NO

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (Please check yes or no)

Symptom	Yes	No
Are you in generally good health?		
Do you have problems with bleeding?		
Do you have problems with healing?		
Do you have any new or changing skin lesions?		

Signature: _____ **Date:** _____