Date: _____

PATIENT INFORMATION

PATIENT _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____ SPOUSE'S NAME _____

ADDRESS _____

PHONE _____ CELL _____ EMAIL _____

EMPLOYER _____ POSITION _____

EMPLOYER'S ADDRESS _____ PHONE _____

FAMILY PHYSICIAN _____ REFERRED BY _____

RESPONSIBLE PARTY IF PATIENT IS A MINOR: _____

ADDRESS: _____ PHONE _____

NUMBER STREET CITY OR TOWN ZIP CODE

INSURANCE INFORMATION

SUBSCRIBER _____ RELATIONSHIP _____ DATE OF BIRTH: _____

PRIMARY I.D.# _____ SECONDARY I.D.# _____

OTHER _____ PRESCRIPTION I.D.# _____

DERMATOLOGY MEDICAL HISTORY

Reason for Today's Visit _____

Are you allergic to any medications? ❑ Yes ❑ No If yes, list: _____

List all medications you are currently taking

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Do you have, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis	❑	❑
Emphasema	❑	❑
Asthma	❑	❑

Cardiovascular:	YES	NO
High Blood Pressure	❑	❑
Heart Attack	❑	❑
Pacemaker	❑	❑

Other Systemic:	YES	NO
Diabetes	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Gastrointestinal	❑	❑
Yeast Infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Artificial Joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

SKIN:

Have you ever had skin cancer? ❑ Yes ❑ No

Has anyone in your family had skin cancer? ❑ Yes ❑ No

Do you develop skin rashes in reaction to Medications Food Environment? _____

(Women) Are you pregnant? ❑ Yes ❑ No Due Date: ___/___/___

Are you interested in any Cosmetic services or skin care products? ❑ Yes ❑ No