Patient Name: _____ Date of Birth: _____

Reason(s) for today's visit: _____

Past Medical History: (Please circle all that apply)

Anxiety	COPD	Hearing Loss	Lung Cancer
Arthritis	Coronary Artery Disease	Hepatitis	Lymphoma
Asthma	COVID-19: Date _____	High Blood Pressure	Pacemaker/Defibrillator
Atrial Fibrillation	Hospitalized Y / N	High Cholesterol	Prostrate Cancer
Benign prostatic hyperplasia	Depression	HIV/AIDS	Radiation Treatment
Bone Marrow Transplant	Diabetes	Hyperthyroid	Seizures
Breast Cancer	End Stage Renal Disease	Hypothyroid	
Cerebrovascular accident	Epilepsy	Inflammatory Disease of Liver	**NONE**
Colon Cancer	GERD	Leukemia	

Other: _____

Past Surgical History: (Please list all that apply) _____

_____

Skin Disease History: (Please circle all that apply)

Acne	Dry/Scaling (Asteatosis Cutis)	Hay Fever/Allergies	Squamous Cell Skin Cancer
Actinic Keratoses	Dysplastic Nevus of Skin	Malignant melanoma	Sunburn of second degree
Basal Cell Skin Cancer	Eczema	Pruritus of scalp	
Contact Derm —> Poison Ivy	History of Asthma	Psoriasis	**NONE**

Other: _____

Do you wear Sunscreen? Yes / No If yes, what SPF? _____

Do you tan in a tanning salon? Yes / No

Do you have a family history of Melanoma? Yes / No If yes, which relative(s)? _____

Family History - First Degree Relative Only [Mother/Father/Brother/Sister/Child]: (If positive, circle all that apply)

Arthritis	Diabetes	Heart Disease	Psoriasis
Cancer	Eczema	High Blood Pressure	

Females Only:

Are you Pregnant or Breast Feeding?	Yes / No	Are you Planning a Pregnancy?	Yes / No
Do you have a regular Cycle?	Yes / No	Are you on an Oral Contraceptive?	Yes / No

Medications: (Please list all current medications) _____

_____

_____Initial: _____Date:_____

Allergies: (Please list all allergies) _____

_____

Social History: (Please circle all that apply)

Cigarette Smoking: Never Smoked / Quit: Former Smoker / Smokes Less Than Daily / Smokes Daily

Alcohol Use: None / Less than 1 drink per day / 1-2 drinks per day / 3 or more drinks per day

Immunizations: (Please circle all that apply)

Flu Vaccine: Never / Yearly Pneumonia Vaccine: (under 65 years) = N/A COVID-19 Vaccine: _____

(over 65 years) = Yes / No # Doses: _____

Patient Name: _____ Date of Birth: _____

To help our practice comply with government mandated programs,
please complete the following in its entirety.

Language: _____

Race: (Please circle)

White
American Indian or Alaskan Native
Asian
Black or African American
Native Hawaiian or other Pacific Islander

Ethnicity: (Please circle)

Hispanic or Latino
Not Hispanic or Latino

Preferred Contact Method: (Please circle)

Patient Portal
Phone

Primary Care Physician: _____

Pharmacy:

Name:_____

Address: _____

Do you currently have any of the following symptoms? (Please check YES or NO)

Acne	[ ] yes	[ ] no	Hayfever	[ ] yes	[ ] no
Anxious feelings	[ ] yes	[ ] no	Slow healing after injury	[ ] yes	[ ] no
Lengthy bleeding when cut	[ ] yes	[ ] no	Joint pain	[ ] yes	[ ] no
Breathing difficulties	[ ] yes	[ ] no	Keloids or thick scars	[ ] yes	[ ] no
Cardiovascular problems	[ ] yes	[ ] no	Muscle weakness	[ ] yes	[ ] no
Chest symptoms	[ ] yes	[ ] no	Nausea and vomiting	[ ] yes	[ ] no
Deepening of voice	[ ] yes	[ ] no	Pain with deep breaths	[ ] yes	[ ] no
Difficulty hearing	[ ] yes	[ ] no	Psychiatric or emotional difficulties	[ ] yes	[ ] no
Dry skin	[ ] yes	[ ] no	Reddening of the face	[ ] yes	[ ] no
Epilepsy / Seizures	[ ] yes	[ ] no	Seasonal allergies	[ ] yes	[ ] no
Excess hair growth	[ ] yes	[ ] no	Sores or ulcers in mouth	[ ] yes	[ ] no
Fatigue	[ ] yes	[ ] no	Stomach or intestinal problems	[ ] yes	[ ] no
Feeling of sand in eyes	[ ] yes	[ ] no	Unintentional weight loss	[ ] yes	[ ] no
Fever or Chills	[ ] yes	[ ] no	Unwanted hair	[ ] yes	[ ] no
Genital sores	[ ] yes	[ ] no	White patches in mouth	[ ] yes	[ ] no
GI symptoms with antibiotics	[ ] yes	[ ] no	Yeast infections with antibiotics	[ ] yes	[ ] no