## THE DERMATOLOGY CENTER

Cell Phone #:		Carrier:_		
Name Of Patient:				
Last	First	Mi	iddle	Social Security#
Mailing Address:				
Street		City	State	Zip Code
Preferred Phone#			Work#	
Email Address:				Date of Birth:
Occupation		Marital	Status: S M \	W Sex: M F
Race: ASN BLK HSP WH	T Other	Preferred La	anguage: English	n Other
Preferred Pharmacy:		Add	dress:	
In case of emergency notify:				
	Name	Relations	ship Pho	one#
Optional: I authorize the rele	ass of informati	ion to the follow	ving poroen.	
			ing person:	
<u>lf Minor</u> - Information on Pare	∍nt/Guardian Re	questing Care:		
Name:				
Last	First	Mic	ddle	Social Security#
Address (if different:)				
Street		City	State	Zip Code
Date of Birth:			Employer: ——	
Preferred Phone#			Work#	
Insured's Information (if diffe	rent from Patier	nt/Parent/Guard	ian)	
Name:				
Last Address (if different):	First	Mic	ddle	Social Security#
Street Date of Birth:		City	State	Zip Code
Date of birth.			Employer:	
Preferred Phone#			Work#	
I authorize the Dermatology information needed for, or rela original, and request payment or acknowledge that I am awar notice. I give the Center, it's em of treatment, insurance or payr	ited to my claim. of medical insural e of the Centers p ployees and ager	I permit a copy once benefits to morivacy practice no	of this authorizat nyself or the Derr otice, and that I m	tion to be used in place of the matology Center. nay have a written copy of suc
Signature of Patient - Parent/G	uardian M	//inor: Signature o	of Patient (14 -18	Byears of age) Date

## **Health History**

Melanoma

Psoriasis

Skin Cancer

**Family History:** Circle any of the following that a blood relative has been treated for.

Heart Disease

Eczema

High Blood Pressure

Cancer (non-skin)

Provider Initials \_\_\_\_\_

Depression

Diabetes

Anemia Diabetes Hepatitis Stroke Arthritis Easy Bleeding/Bruising High Blood Pressure Thyroid Disease Asthma Gl/Bowel Disease High Cholesterol Tuberculosis  Other Prior Illnesses:  Previous Surgeries:  Medications you are taking:  Social History:  Do you smoke tobacco? YES # Packs per day #Years NO  Former smoker # Packs per day Date Quit: #Years  Do you drink alcohol? Never Socially Daily  Do you use a tanning bed? Yes No Previously Used  Do you use sunscreen? Daily Sometimes Always, if sunny Rarely/Never  Do you have an Advance Directive/Living Will? YES NO  Review of Systems: Circle any of the following that you have been treated for in the past year.  Weight loss/gain Blood in urine Depression  Dry Eyes Arthritis Diabetes  Mouth Sores Skin cancer Anemia  Chest Pain Rash Allergies  Chronic Cough Migraines Chronic Diarrhea  Flu Vaccination  Drug Allergies: None Known Yes, list:  I verify that the above information is true and accurate to the best of my knowledge.	Aids/HIV	Cancer		Heart Disease	/Attack	Kidney Disease	
Arthritis Easy Bleeding/Bruising High Blood Pressure Thyroid Disease Ashma Gl/Bowel Disease High Cholesterol Tuberculosis  Other Prior Illnesses:  Previous Surgeries:  Medications you are taking:  Social History:  Do you smoke tobacco? YES # Packs per day #Years NO Former smoker # Packs per day Date Quit: #Years  Do you drink alcohol? Never Socially Dailly Do you use a tanning bed? Yes No Previously Used Do you use sunscreen? Daily Sometimes Always, if sunny Rarely/Never Do you have an Advance Directive/Living Will? YES NO  Review of Systems: Circle any of the following that you have been treated for in the past year. Weight loss/gain Blood in urine Depression Dry Eyes Arthritis Diabetes Mouth Sores Skin cancer Anemia Chest Pain Rash Allergies Chronic Cough Migraines Chronic Diarrhea Flu Vaccination  Drug Allergies: None Known Yes, list:  I verify that the above information is true and accurate to the best of my knowledge.		Diabetes			Attack	Stroke	
Asthma GI/Bowel Disease High Cholesterol Tuberculosis  Other Prior Illnesses: Previous Surgeries:  Medications you are taking:  Social History: Do you smoke tobacco? YES # Packs per day #Years NO Former smoker # Packs per day Date Quit: #Years Do you drink alcohol? Never Socially Daily Do you use a tanning bed? Yes No Previously Used Do you use sunscreen? Daily Sometimes Always, if sunny Rarely/Never Do you have an Advance Directive/Living Will? YES NO  Review of Systems: Circle any of the following that you have been treated for in the past year. Weight loss/gain Blood in urine Depression Dry Eyes Arthritis Diabetes Mouth Sores Skin cancer Anemia Chest Pain Rash Allergies Chronic Cough Migraines Chronic Diarrhea Flu Vaccination  Drug Allergies: None Known Yes, list:  I verify that the above information is true and accurate to the best of my knowledge.				•	essure		
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Social History:  Do you smoke tobacco? YES # Packs per day #Years NO  Former smoker # Packs per day Date Quit: #Years  Do you drink alcohol? Never Socially Daily  Do you use a tanning bed? Yes No Previously Used  Do you use sunscreen? Daily Sometimes Always, if sunny Rarely/Nevel  Do you have an Advance Directive/Living Will? YES NO  Review of Systems: Circle any of the following that you have been treated for in the past year.  Weight loss/gain Blood in urine Depression  Dry Eyes Arthritis Diabetes  Mouth Sores Skin cancer Anemia  Chest Pain Rash Allergies  Chronic Cough Migraines Chronic Diarrhea  Flu Vaccination  Drug Allergies: None Known Yes, list:	Other Prior Illness	ses:					
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Former smoker # Packs per day Date Quit: #Years Do you drink alcohol? Never Socially Daily  Do you use a tanning bed? Yes No Previously Used  Do you use sunscreen? Daily Sometimes Always, if sunny Rarely/Never Do you have an Advance Directive/Living Will? YES NO  Review of Systems: Circle any of the following that you have been treated for in the past year.  Weight loss/gain Blood in urine Depression  Dry Eyes Arthritis Diabetes  Mouth Sores Skin cancer Anemia  Chest Pain Rash Allergies  Chronic Cough Migraines Chronic Diarrhea  Flu Vaccination  Drug Allergies: None Known Yes, list:	Social History:						
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Do you use a tanning bed? Yes No Previously Used Do you use sunscreen? Daily Sometimes Always, if sunny Rarely/Nevel Do you have an Advance Directive/Living Will? YES NO  Review of Systems: Circle any of the following that you have been treated for in the past year. Weight loss/gain Blood in urine Depression Dry Eyes Arthritis Diabetes Mouth Sores Skin cancer Anemia Chest Pain Rash Allergies Chronic Cough Migraines Chronic Diarrhea  Flu Vaccination  Drug Allergies: None Known Yes, list:  I verify that the above information is true and accurate to the best of my knowledge.		Form	ier smoker # F	Packs per day	Date Qu	it: #Years	
Do you use sunscreen? Daily Sometimes Always, if sunny Rarely/Never Do you have an Advance Directive/Living Will? YES NO  Review of Systems: Circle any of the following that you have been treated for in the past year. Weight loss/gain Blood in urine Depression Dry Eyes Arthritis Diabetes Mouth Sores Skin cancer Anemia Chest Pain Rash Allergies Chronic Cough Migraines Chronic Diarrhea  Flu Vaccination  Drug Allergies: None Known Yes, list:  I verify that the above information is true and accurate to the best of my knowledge.	Do you drink alco	hol?	Never	Socially	Daily		
Do you use sunscreen? Daily Sometimes Always, if sunny Rarely/Never Do you have an Advance Directive/Living Will? YES NO  Review of Systems: Circle any of the following that you have been treated for in the past year.  Weight loss/gain Blood in urine Depression  Dry Eyes Arthritis Diabetes  Mouth Sores Skin cancer Anemia  Chest Pain Rash Allergies  Chronic Cough Migraines Chronic Diarrhea  Flu Vaccination  Drug Allergies: None Known Yes, list:  I verify that the above information is true and accurate to the best of my knowledge.	Do you use a tanr	ning bed?	Yes	No	Previou	sly Used	
Review of Systems: Circle any of the following that you have been treated for in the past year.  Weight loss/gain Blood in urine Depression Dry Eyes Arthritis Diabetes  Mouth Sores Skin cancer Anemia Chest Pain Rash Allergies Chronic Cough Migraines Chronic Diarrhea  Flu Vaccination  Drug Allergies: None Known Yes, list:  I verify that the above information is true and accurate to the best of my knowledge.				Sometimes			
Weight loss/gain  Dry Eyes  Arthritis  Mouth Sores  Skin cancer  Chest Pain  Chronic Cough  Migraines  Chronic Diarrhea  Flu Vaccination  Prug Allergies:  None Known  Yes, list:  I verify that the above information is true and accurate to the best of my knowledge.	Do you have an A	dvance Dir	ective/Living Wil	ll? YES	NO	,	
Dry Eyes Arthritis Diabetes  Mouth Sores Skin cancer Anemia Chest Pain Rash Allergies Chronic Cough Migraines Chronic Diarrhea  Flu Vaccination  Drug Allergies: None Known Yes, list:  I verify that the above information is true and accurate to the best of my knowledge.	Review of Syster	ms: Circle	any of the follow	ing that you have	been treated	I for in the past year.	
Mouth Sores Skin cancer Anemia Chest Pain Rash Allergies Chronic Cough Migraines Chronic Diarrhea Flu Vaccination  Drug Allergies: None Known Yes, list:  I verify that the above information is true and accurate to the best of my knowledge.	Weight loss/gain		Blood	d in urine	De	pression	
Chest Pain Rash Allergies Chronic Cough Migraines Chronic Diarrhea  Flu Vaccination  Drug Allergies: None Known Yes, list:  I verify that the above information is true and accurate to the best of my knowledge.	Dry Eyes Arthritis		tis	Dia	abetes		
Chronic Cough Migraines Chronic Diarrhea  Flu Vaccination  Drug Allergies: None Known Yes, list:  I verify that the above information is true and accurate to the best of my knowledge.	• •				An	emia	
Prug Allergies: None Known Yes, list:  I verify that the above information is true and accurate to the best of my knowledge.	Mouth Sores				, and the second se		
Drug Allergies: None Known Yes, list:  I verify that the above information is true and accurate to the best of my knowledge.	Mouth Sores Chest Pain					•	
I verify that the above information is true and accurate to the best of my knowledge.	Mouth Sores Chest Pain Chronic Cough					•	
	Mouth Sores Chest Pain Chronic Cough					•	
	Mouth Sores Chest Pain Chronic Cough Flu Vaccination	None K	Migra	iines	Ch	ronic Diarrhea	
V	Mouth Sores Chest Pain Chronic Cough Flu Vaccination Drug Allergies:		Migra (nown Ye	nines s, list:	Ch	ronic Diarrhea	
V	Mouth Sores Chest Pain Chronic Cough Flu Vaccination Drug Allergies:		Migra (nown Ye	nines s, list:	Ch	ronic Diarrhea	
	Mouth Sores Chest Pain Chronic Cough Flu Vaccination Drug Allergies:		Migra (nown Ye	nines s, list:	Ch	ronic Diarrhea	