SelectSkinMD
DERMATOLOGY | SKIN CANCER SPECIALISTS

Date:_____

LEGAL Name: _____ Soc. Sec# _____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____

Email Address: _____

Spouse or Parent / Guardian : _____

Mailing Address: _____ City / State: _____ Zip: _____

Seasonal Address: _____ City / State: _____ Zip: _____

Home Phone: _____ Cell: _____

Preferred Language: _____ Race: _____ Ethnic Group:_____

Employer: _____ Employer Phone: _____

Friend or relative <u>not living with you</u> that we may contact in case of emergency (REQUIRED):

Name: _____ Telephone: _____

Referring Physician : _____ City: _____ State:_____

Regular Physician : _____ City: _____ State: _____

Preferred Pharmacy

Name: _____ Street / City: _____

WE WILL NEED TO COPY ALL OF YOUR CURRENT INSURANCE CARDS FOR OUR RECORDS

<u>Policy Holder's Insurance Information is REQUIRED to file to Insurance</u>

Primary Insurance Company

Insurance Co Name: _____ ID # : _____

Name: _____ Date of Birth: _____ Soc. Sec #: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Employer Phone: _____

Secondary Insurance Company

Insurance Co Name: _____ ID # : _____

Name: _____ Date of Birth: _____ Soc. Sec #: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____
_____
_____

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Live: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Postate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids

- [ ] Uterus (Hysterectomy): Cervical Cancer

- [ ] NONE
- [ ] Other

_____
_____
_____

Skin Disease History

Have you had any of the following?

- [ ] Acne
- [ ] Actinic Keratoses
- [ ] Asthma
- [ ] Basal Cell Skin Cancer
- [ ] Blistering Sunburns
- [ ] Dry Skin
- [ ] Eczema
- [ ] Flaking or Itchy Scalp
- [ ] Have Fever / Allergies
- [ ] Melanoma
- [ ] Poison Ivy
- [ ] Precancerous Moles
- [ ] Psoriasis
- [ ] Squamous Cell Skin Cancer
- [ ] 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?

- [ ] Mother
- [ ] Father
- [ ] Sister
- [ ] Brother
- [ ] Daughter
- [ ] Son
- [ ] Uncle
- [ ] Aunt
- [ ] Nephew
- [ ] Niece
- [ ] Grandmother
- [ ] Grandfather
- [ ] Grandson
- [ ] Granddaughter
- [ ] Other

_____
_____

Medications

List all current medications:

_____
_____
_____

Allergies

List all allergies and reactions if known:

_____
_____

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

Occupation and Workplace:

_____
_____

Place of Residence:

_____
_____

Family History

Please include only first-degree relatives:

_____

_____

Review of Systems

Do you have any of the following?

- ☐ Problems with Bleeding
- ☐ Problems with Healing
- ☐ Problems with Scarring (hypertrophic or keloid)
- ☐ Rash
- ☐ Immunosuppression
- ☐ Hay Fever
- ☐ Allergy to Topical Antibiotic Ointment
- ☐ Chest Pain
- ☐ Fever or Chills
- ☐ Night Sweats
- ☐ Unintentional Weight Loss
- ☐ Sore Throat
- ☐ MRSA
- ☐ Blurry Vision
- ☐ Abdominal Pain
- ☐ Thyroid Problems
- ☐ Bloody Stool
- ☐ Joint Aches
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Anxiety
- ☐ Depression
- ☐ Changing Mole
- ☐ Blood Thinners

Alerts

Do you have any of the following?

- ☐ Allergic to Adhesive
- ☐ Allergic to Lidocane
- ☐ Artificial Heart Valve
- ☐ Artificial Joints within the past two years
- ☐ Premedication Prior to Procedures