seaside DERMATOLOGY

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NEW PATIENT PAPERWORK

Full Name:______________________________

Date of Birth:______________________________

Address: ______________________________
____
____

Social Security Number: ____ -- ____ -- _____
Gender: ______________________________
Primary Phone: (_____)_______-_______________
Work Phone: (_____)_______-_______________
Mobile Phone: (_____)_______-_______________
OK to leave detailed messages by phone? Yes___No___

Email Address (**required**):______________________________
Emergency Contact Name:______________________________
Emergency Contact Phone: (_____)_______-_______________
Pharmacy Name and City:______________________________
Employment:______________________________

Providers:
Primary Care Physician: ______________________ Fax # ***(required)***______________________
Referring Physician: ______________________ Fax # ***(required)***______________________

Past Medical History:

- **NO PAST MEDICAL HISTORY**
- **Anxiety**
- **Arthritis**
- **Asthma**
- **Atrial Fibrillation**
- **Bone Marrow Transplantation**
- **GERD**
- **BPH**
- **Breast Cancer**
- **Colon Cancer**
- **COPD**
- **Coronary Artery Disease**
- **Depression**
- **Diabetes**
- **End Stage Renal Disease**
- **Hearing Loss**
- **Hepatitis**
- **Hypertension**
- **HIV/AIDS**
- **Hypercholesterolemia**
- **Hypothyroid**
- **Hyperthyroidism**
- **Leukemia**
- **Lung Cancer**
- **Lymphoma**
- **Prostate Cancer**
- **Radiation Treatment**
- **Seizures**
- **Stroke**
- Currently Pregnant or Planning Pregnancy
- **Other:**

Past Surgeries: ______________________________
____
____

Skin Disease History:

Have you had any of the following skin conditions?

- ○ **Acne**
- ○ **Actinic Keratosis**
- ○ **Asthma**
- ○ **Basal Cell Skin Cancer**
- ○ **Blistering Sunburns**
- ○ **Dry Skin**
- ○ **Eczema**
- ○ **Flaking or Itching Scalp**
- ○ **Hay fever/Allergies**
- ○ **Melanoma**
- ○ **Poison Ivy**
- ○ **Precancerous Moles**
- ○ **Psoriasis**
- ○ **Squamous Cell Skin Cancer**
- ○ **Other**

Do you wear sunscreen? Y N

If yes, what SPF? ________________SPF

Do you tan at a tanning salon? Y N

Family History:

Do you have a family history of Melanoma? Y N

If yes, which relative? _______________

Social History:

Are you currently or have you ever been a smoker? Y N

Start smoking date: _________________

Quit smoking date: _________________

Number of packs per day: ____________

Total number of years a smoker: _____

Have you received a pneumonia vaccine this year? Y N

If yes, when? _________________

Medication Allergies	Reaction
Example: Penicillin	Rash

Medication	Dosage	Frequency
Example: Aspirin	81 mg	Daily