GERIA DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

Date: __________________
Last Name: ____________________ Middle Initial: _____ First Name: ______________________
Birthday: _____/_____/________ Sex: **M/F** Marital Status (Circle one): **Single/ Married/ Divorced/ Domestic Partner/ Separated/ Widowed**

Address: _______________________________________City: _________________ State: ______
Zip: ______ Home Phone:_________________________ Cell Phone:_______________________
Email: ___________________________
Occupation: ____________________________ Work Phone: _____________________________

Emergency Contact

Name: _______________________________ Phone: _____________________________________
Relationship: __________________________

Primary Physician

Name: ____________________________ Phone: ____

Pharmacy

Pharmacy Name: ________________________Town: _______________________ Zip: _________ Phone # _____________________

Insurance Information

Primary Insurance:________________ Policy Holder:________________ Relationship: ________
Insured DOB: ___________________________ Policy #: _________________________________
Group #: _________________ Referral YES/NO
Secondary Insurance: ______________ Policy Holder: _______________ Relationship: _______
Insured DOB: ___________________________ Policy #: _________________________________
Group #: __________________ Referral YES/NO

Signature: ____________________________________ **Date:** ____________________________

Medical History

Reason for today's visit: ____

Current Conditions: (Please check all that apply)

___ None
___ Anxiety disorder
___ Arthritis (specify)__________________
___ Asthma
___ Atrial fibrillation
___ Benign prostatic hyperplasia
___ Cerebrovascular accident
___ Seizures
___ Pacemaker
___Chronic obstructive lung disease
___ Coronary arteriosclerosis
___ History of fainting
___ Depressive disorder
___ Elevated blood pressure
___ Diabetes
___ GERD
___ HIV/ AIDS
___ End-stage renal disease
___ Thyroid Problems (specify)____________
___ Epilepsy
___ Stroke
___ Defibrillator
___ Hypertension
___ Hearing loss
___ Hypercholesterolemia
___ Inflammatory disease of liver
___ Leukemia
___ Radiation therapy (specify)____________

Other: ____

Skin History: (Please check all that apply)

___ None
___ Skin Cancer (specify)________________
___ Melanoma (location/ year)
___ Eczema
___ Atypical Moles
___ Hives
___ Seasonal Allergies
___ Scarring/ Keloids
___ Actinic Keratosis (pre- cancers)
___ Cancer (specify) _____________
___ Psoriasis
___ Herpes Simplex (cold sores)
___ MRSA
___ Bleeding/ Clotting Disorders
___ Acne

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Family History of Melanoma/ Skin Cancer: Yes/ No (specify) _________________________

Past Surgical History/ Hospitalizations:
____

Medications (prescriptions, over the counter, vitamins, supplements):
____

Allergies: ____
Allergies to Bacitracin/ Latex/ Epinephrine/ Adhesives: (circle if applicable) Yes/ No

Social History

Tobacco: Yes/ No Former smoker: Yes/ No If yes, how much? _________________________
Alcohol: Yes/ No/ Occasional If yes, ____________ drinks per day/ week
IV Drugs: Yes/ No If yes, what? ___________________ How often? ____________________
Driving status: Drive in the daytime/ Drive in the nighttime
Do you exercise? Yes/ No
Do you drink coffee? Yes/ No

Sun History

Do you wear sunscreen? Yes/ No If yes, what SPF? ________________________________
Have you ever used a tanning booth? Yes/ No If yes, how often? ________________________
Have you had sunburns in the past? Yes/ No If yes, estimate how many? __________________
Do you tan in tanning salon? Yes/ No

Patients 65 and older

Do you have a health care proxy? Yes/ No
Do you have a living will? Yes/ No
Did you have the pneumonia vaccine? Yes/ No

Female Patients

Date of last menstrual period? _____________________
Are you pregnant? Yes/ No
Are you nursing? Yes/ No

Signature: ___________________________________ **Date:** ___________________________