The Skin Clinic

Ardmore / Ada / Duncan / Durant

Patient Name: _____ Date: _____

Mailing Address:_____ City/State: _____

Zip Code: _____ Date of Birth: _____ Birth Gender: _____

Primary Phone: _____ Work Phone: _____

Email Address: _____ SSN: _____

Emergency Contact Name: _____ Phone Number: _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Pharmacy: _____ Phone: _____

Address: _____ City/State: _____ Zip Code: _____

Insurance Information

Primary Insurance: _____

Policy Holder: _____ Date of Birth: _____

Policy Number/ID: _____ Group Number/ID: _____

Secondary Insurance: _____

Policy Holder: _____ Date of Birth: _____

Policy Number/ID: _____ Group Number/ID: _____

Guarantor Information (<u>Mandatory for patients under the age of 18)</u>

Name: _____ Relationship to Patient: _____

Date of Birth: _____/_____/_____ Social Security Number : _____

Mailing Address: _____ City/State: _____

Zip Code: _____ Preferred Phone Number: _____

Past Medical Conditions

___ NONE
___ Anxiety Disorder
___ Arthritis
___ Asthma
___ Atrial Fibrillation
___ Cerebrovascular Accident (Stroke)
___ Chronic Obstructive Lung Disease (COPD)
___ Coronary Arteriosclerosis
___ Depressive Disorder
___ Diabetes
___ Elevated Blood Pressure
___ End Stage Renal Disease
___ H/O: Hypertension
___ Hearing Loss
___ Human Immunodeficiency Virus (HIV)
___ Hypercholesterolemia
___ Leukemia
___ Malignant Lymphoma
___ Malignant Tumor of Colon
___ Malignant Tumor of Lung
___ Radiation Therapy Treatment

Other: _____
_____

Past Surgeries

___ NONE
___ Biopsy of Prostate
___ Coronary Artery Bypass Graft
___ Entire Transplant Kidney
___ Excision of Basal Cell Carcinoma
___ Excision of Melanoma
___ Excision of Squamous Cell Carcinoma
___ H/O: Tubal Ligation
___ History of Bilateral Mastectomy
___ History of Colectomy
___ Percutaneous Transluminal Coronary Angioplasty
___ Hysterectomy
___ Lumpectomy of Breast Right / Left
___ Mastectomy of Breast Right / Left
___ Mechanical Heart Valve Replacement
___ Surgical Biopsy of Skin
___ Total Replacement of Knee Joint Right / Left
___ Total Replacement of Hip Joint Right / Left
___ Transplantation of Heart
___ Transplantation of Liver

Other:
_____
_____

Skin Conditions

___ None

___ Acne

___ Actinic Keratosis

___ Basal Cell Carcinoma

___ Dermatitis due to Poison Ivy

___ Dysplastic Nevus

___ Eczema

___ Malignant Melanoma

___ Psoriasis

___ Squamous Cell Carcinoma

___ Sunburn of second degree

Other:

_____

Skin Protection

Do you wear sunscreen?

___ Yes ___ No

If so, what SPF? _____

Do you tan in a tanning salon?

___ Yes ___ No

Family History of Melanoma

___ NONE

___ Mother

___ Father

___ Sister

___ Brother

___ Daughter

___ Son

___Uncle

___ Aunt

___ Nephew

___ Grandmother

___ Grandfather

___ Grandson

___ Granddaughter

Other:

_____

Current Medications

Please list all medication and supplements you are currently taking or provide a list.

Drug: Dosage:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies

Please list all known allergies along with reactions.

_____

_____

_____

Smoking Habits

___ Current Smoker ___ Former Smoker ___ Never

Alcohol and Drug Use

Do you consume alcohol?

___ None ___ 1-2 per day

___ Less than 1 per day ___ 3 or more per day

Do you use illegal drugs? ___ Current ___ Former ___ Never

Patient Occupation

What is your current occupation & place of employment?

_____ / Retired

Patient Implantable Device

Please list all below:

_____

_____

Patient's Family History

Please list the afflicted family member; blood relatives only.

___Adopted

Abnormal Bleeding _____

Abnormal Clotting _____

Autoimmune Disorder _____
(Lupus, Rheumatoid Arthritis, Multiple Sclerosis)

Brain Tumor _____

Breast Cancer _____

Diabetes (type 1 / type 2) _____

Endocrine Disease (Thyroid) _____

Heart Disease _____

Hemophilia (excessive bleeding) _____

High Blood Pressure _____

Kidney Disease _____

Liver Disease _____

Lung Cancer _____

Malignant Melanoma _____

Other Cancer _____

Ovarian Cancer _____

Prostate Cancer _____

Skin Cancer _____

Skin Disease _____

Other _____

_____