HIGHLINE DERMATOLOGY & SKIN CANCER

Full Name: _____ Date: _____

Mailing Address: _____

City / State: _____ Zip Code: _____

Date of Birth: _____ SSN: _____ Gender: M F

Phone Number (cell): _____ Phone Number (home): _____

Okay to leave a detailed message? Y N

Okay to send an appointment reminder text message? Y N

Email Address: _____

Emergency Contact :_____ Phone: _____

Preferred Language: _____ Ethnicity: _____

Primary Care Provider: _____

Preferred Pharmacy

Name: _____

City: _____

Past Medical History

Select any of the following medical conditions you have now or previously have had:

- ☐ NONE
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (AFib)
- ☐ Benign prostatic hyperplasia (enlarged prostate)
- ☐ Cerebrovascular accident (stroke)
- ☐ Chronic obstructive lung disease (COPD)
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Gastro-esophageal reflux disease (GERD)
- ☐ Hearing Loss
- ☐ Human immunodeficiency virus infection (HIV)
- ☐ Hypercholesterolemia (high cholesterol)
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Liver disease, hepatitis
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of lung
- ☐ Malignant tumor of breast
- ☐ Malignant tumor of colon
- ☐ Malignant tumor of prostate
- ☐ Malignant tumor, other _____
- ☐ Radiation therapy
- ☐ Transplantation of bone marrow
- ☐ Other organ transplant _____

Other

_____

_____

Past Surgical History

Please list any previous surgeries:

_____

_____

_____

_____

_____

Skin Disease History

Have you had any of the following?

- ☐ NONE
- ☐ Acne
- ☐ Actinic keratosis (pre-cancers of skin)
- ☐ Asteatosis cutis (dry skin)
- ☐ Basal cell skin cancer
- ☐ Poison ivy
- ☐ Dysplastic nevus of skin (abnormal moles)
- ☐ Eczema
- ☐ Asthma
- ☐ Hay fever
- ☐ Malignant melanoma
- ☐ Itchy scalp
- ☐ Psoriasis
- ☐ Squamous cell skin cancer
- ☐ Sunburn (severe)
- ☐ Other

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 or supply us with a list:

_____

_____

_____

_____

Allergies

List all allergies and reactions if known:

_____

_____

_____

Social History

Smoking Status (please circle one):

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

Started Smoking
- mm/dd/yyyy _____

Quit Smoking
- mm/dd/yyyy _____

Number of Packs Per Day: _____ Total Years Smoking: _____

Alcohol Intake:
How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____

Do you consume alcohol (etOH or grain alcohol)? *Circle one*

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

☐ Illicit drug use

Occupation and workplace:

_____ _____

Family History

Please include relevant information about first-degree relatives only:

_____

_____

_____

Authorization

Are we authorized to discuss your care with anyone over the phone?

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

_____ _____

Signature **Date**

By signing above I authorize the people listed to discuss all aspects of my care with the staff at Highline Dermatology and Skin Cancer. Further consent will be needed for disclosures of a non-verbal nature.