**Advanced Dermatology, PC**
Skin Cancer Surgery & Skin Care Center

# Patient History and Intake Form

Patient Name:_____ Date of Birth: _____ Sex ( ) M ( ) F
First MI Last Suffix

Address:_____
Street Apt# City State Zip Code

Social Security #_____( ) Married ( ) Single ( ) Minor ( ) Employed ( ) Retired ( ) Student ( ) Other

Home Phone (____)_____ Mobile (____)_____ Can we leave a message: Yes or No

Email:_____ Occupation:_____

Spouse's/Parent/Guardian's Name:_____ Phone (____)_____

Address:_____
Street Apt# City State Zip Code

Emergency Contact:_____Relationship:_____ Phone (____)_____

Health Care Proxy:_____ Relationship:_____ Phone (____)_____

**Personal/Social Health History: (Please circle all that apply): Height_____ Weight_____**

How many times in the past year have you had 5 or more drinks in a day (men), 4 or more drinks in a day (women) and any adult older than 65?_____

**Cigarette Smoking for Adolescents and Adults:** Never Smoked Currently Smokes Former Smoker

**Alcohol Use:** None Less than 1-2 drinks per day 3 or more drinks per day

**Exercise:** Once a day Few times a week Never

**Immunizations: Flu Vaccine:** Previously received Not received Allergy to vaccine
**For ages 65 or older: Pneumonia Vaccine**: Previously received Not received Allergy to vaccine

**Advanced Care Plan**: Do you have an Advanced Care/Living Will? Yes No

**Biologic Patients Only:** Date of last Tuberculosis test: _____ Date of Last Blood work:_____

**Medications: (Please list all medications with dosage and frequency. If you have a list of medications and/or allergies that can be photocopied, please let us know)**

Name:_____ Dose:_____ Frequency:_____
Name:_____ Dose:_____ Frequency:_____
Name:_____ Dose:_____ Frequency:_____
Name:_____ Dose:_____ Frequency:_____
Name:_____ Dose:_____ Frequency:_____
Name:_____ Dose:_____ Frequency:_____

**Medication Allergies: (Please list all medications allergies AND what type of reaction was caused):**

Med:_____ Reaction:_____ Med:_____Reaction:_____
Med:_____ Reaction:_____ Med:_____Reaction:_____
Med:_____ Reaction:_____ Med:_____Reaction:_____

Please flip to complete second page

**Primary Care Physician (PCP):** _____

**Pharmacy Information:** Please complete below. If you have a prescription ID# that differs from your medical ID# please let us know:

Pharmacy Name:_____

Address:_____
Street Apt# City State Zip Code

Phone:_____

**If a minor, please complete the information below.**

This information applies in the event that a parent or guardian is unable to attend an appointment with their child. It is essential for the office to know who can make medical decisions if necessary at the time of your appointment.

I, _____ parent/guardian of _____
First Last First Last

give permission to _____, to make medical decisions in my absence pertaining
First Last

to my child's medical treatment.

**Past Medical History: (Please circle all that apply)**

**NONE**

| | | | |
|---|---|---|---|
| Anxiety | Colon Cancer | GERD | Leukemia |
| Arthritis | COPD | Hearing Loss | Lung Cancer |
| Asthma | Coronary Artery Disease | Hepatitis | Lymphoma |
| Atrial fibrillation | Depression | High Blood Pressure | Prostate Cancer |
| Bone Marrow Transplantation | Diabetes | HIV/AIDS | Radiation Treatment Seizures |
| Breast Cancer | End Stage Renal Disease | High Cholesterol | Seizures |
| | | Thyroid Problems | Stroke |

Other:_____

**Past Surgical History: (Please list)**

_____

_____

_____

**Alerts (please circle all that apply):**

**NONE**

Allergy to Adhesive
Allergy to Lidocaine
Allergy to Topical Antibiotics
Artificial Heart Valve
Artificial Joint Replacement
Blood Thinners
Dementia
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to surgical procedure
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant? Yes /No
Are you breast feeding? Yes or No

**Skin Disease History: (Please circle all that apply)**

**NONE**

| | | |
|---|---|---|
| Acne | Eczema | Psoriasis |
| Actinic Keratoses | Flaking or Itchy Scalp | Rosacea |
| Basal Cell Skin Cancer | Melanoma | Squamous Cell Skin Cancer |
| Blistering Sunburns | Poison Ivy | |
| Dry Skin | Precancerous Moles | |

Other:_____

Do you wear Sunscreen? Yes No If yes, what SPF?_____
Do you tan in a tanning salon? Yes No

Family Medical Skin Disease History (immediate relatives **ONLY**):

_____
_____
_____

Do you have a Family History of Melanoma? Yes No

If yes, which relative?_____

**Patient Portal Authorization Form**

**Purpose of this Form:**

The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your email, you will be assigned a username and password. After you registered with our Patient Portal you will be allowed the following:

- Communicate with our staff
- Review and verify your contact information
- Input past medical history/medications/allergies/social history/family history/preferred pharmacy
- View finalized notes and patient handouts

To access the Patient Portal, please follow the steps below:

1. From your Internet Browser, type the following URL into the address bar: **adderm.ema.md**
2. If you provided your email address at the time of your appointment, we will send you link to access the portal. Prior to accessing the portal, you will need to verify your information in the email sent to you by the portal.
3. From the login screen, input your username (which is your email address) and password that you selected.

If you did not provide your email address at the time of your appointment, please call our office to get your log in information.

If you wish to participate in the patient portal, indicate below.

○ Yes, I would like participate and have access in the patient portal. _____
Email Address

○ No, I would not like participate and have access in the patient portal.

Patient Signature:_____