Patient Demographics

Full Legal Name: Last Name First Name Middle

Street Address City State Zip

(_____)_____ _____ _____ _____ _____

Home Phone Sex Marital Status Date of Birth SSN

(_____)_____ (_____)_____ _____

Cell Phone Work Phone e-mail

Race: White Black/ African American American Indian / Alaska Native Asian
Middle Eastern Hispanic Other

Ethnicity: Hispanic or Latino YES NO (circle one)

_____ _____ _____

Employer Employer Address Occupation

Who is your FAMILY PHYSICIAN? _____

Who referred you to our office? (Family Physician, ER, Friend, etc.)_____

Referring Physician Address _____Phone #_____

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PRIMARY INSURANCE POLICY HOLDER INFORMATION OR
RESPONSIBLE PARTY IF NO INSURANCE OR MEDICAID MINOR

Insurance Name_____ Policy Holder Name_____

Policy Holder Address if different_____

Relationship to Insured: Self _____ Spouse ____ Child _____ Other _____

Policy Holder DOB _____ Policy Holder SSN _____

ID # _____ Group#_____

SECONDARY INSURANCE POLICY HOLDER INFORMATION

Insurance Name_____ Policy Holder Name_____

Policy Holder Address if Different_____

Relationship to Insured: Self_____ Spouse ____ Child _____ Other_____

Policy Holder DOB _____ Policy Holder SSN_____

ID #_____ Group#_____

I hereby authorize my insurance benefits (medical and/or surgical to include major medical benefits) to be paid directly to Dermatologists of Southwest Ohio. I also recognize that I am responsible to pay for my copays/non-covered services at the time of service. I hereby authorize the release of pertinent medical information to the above name insurance carrier(s).

Signature:_____Date:_____

PATIENT INFORMATION

Name: Date of Birth: Account #:

Latex allergy? ❑ Yes ❑ No

Any drug allergies? ❑ Yes ❑ No

If yes, list any drugs you are allergic to:

MEDICAL SYMPTOMS Please check all the apply

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial fibrillation
- ❑ Bone Marrow Transplant
- ❑ BPH (benign prostatic hyperplasia)
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary artery disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV/AIDS
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung cancer
- ❑ Lymphoma
- ❑ Prostate cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ Other _____
- ❑ None

Have you had any surgeries on the following Organs Please check all the apply

- ❑ Appendix: (appendectomy)
- ❑ Bladder: (cystectomy)
- ❑ Breast: Breast Biopsy
- ❑ Breast: Lumpectomy (both breasts)
- ❑ Breast: Lumpectomy (left breast)
- ❑ Breast: Lumpectomy (right breast)
- ❑ Breast: Mastectomy (both breasts)
- ❑ Breast: Mastectomy (left breasts)
- ❑ Breast: Mastectomy (right breasts)
- ❑ Colon (colectomy): Colon Cancer Resection
- ❑ Colon (Colectomy): Diverticulitis
- ❑ Colon (Colectomy): Inflammatory Bowel
- ❑ Colon: Colostomy
- ❑ Gallbladder: (cholecystectomy)
- ❑ Heart: Biological Valve Replacement
- ❑ Heart: Coronary Artery Bypass
- ❑ Heart: Heart Transplant
- ❑ Heart: Mechanical Valve Replacement
- ❑ Heart: PTCA (angioplasty)
- ❑ Joint Replacement: Hip (both)
- ❑ Joint Replacement: Hip (left)
- ❑ Joint Replacement: Hip (right)
- ❑ Joint Replacement: Knee (both)
- ❑ Joint Replacement: Knee (left)
- ❑ Joint Replacement: Knee (right)
- ❑ Kidney: Kidney Biopsy
- ❑ Kidney: Kidney Stone Removal
- ❑ Kidney: Kidney Transplant
- ❑ Liver: Hepatectomy
- ❑ Liver: Liver Transplant
- ❑ Liver: Shunt
- ❑ Ovaries: (oophorectomy): Endometrosis
- ❑ Ovaries: (oophorectomy): Ovarian Cancer
- ❑ Ovaries: Tubal Ligation
- ❑ Pancreas: Pancreatectomy
- ❑ Prostate: (prostatectomy): Prostate Biopsy
- ❑ Prostate: (prostatectomy): Prostate Cancer
- ❑ Prostate: (prostatectomy): TURP (transurethral resection)
- ❑ Rectum: APR (abdominal perineal resection)
- ❑ Rectum: Low anterior resection
- ❑ Skin: Basal Cell Carcinoma
- ❑ Skin: Melanoma
- ❑ Skin: Skin Biopsy
- ❑ Skin: Squamous Cell Carcinoma
- ❑ Spleen: (splenectomy)
- ❑ Testicles: (orchiectomy)
- ❑ Uterus: (hysterectomy): Fibroids
- ❑ Uterus: (hysterectomy): Uterine Cancer
- ❑ Uterus: (hysterectomy): Cervical Cancer
- ❑ Other _____
- ❑ None

Have you had any of the following conditions:

- ❑ Acne
- ❑ Actinic Keratosis (pre skin cancer)
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever/Allergies
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Precancerous Moles
- ❑ Psoriasis
- ❑ Squamous Cell Skin Cancer
- ❑ Other _____
- ❑ None

Do you wear sunscreen? ❑ Yes ❑ No

If Yes, what SPF?

Do you tan in a tanning salon? ❑ Yes ❑ No

Are you currently pregnant? ❑ Yes ❑ No

Previous history of pregnancies/births (list years)

Do you have a family history of melanoma? ❑ Yes ❑ No

If yes, which relative?

Signature of Responsible Party /Date _____

- **Are you currently taking any of the following?** ❑ Coumadin/Wafarin ❑ Pradaxa ❑ Effient ❑ Plavix ❑ Aspirin

Medications (list all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary supplements as well as name/dosage/freq/route)

Medication Name	Dosage	Frequency	Route

SOCIAL HISTORY

Tobacco Products Use?
❑ Current every day smoker
❑ Former every day smoker
❑ Never

Date Started/Quit
_____

Have you ever tested positive for TB?
❑ Yes ❑ No

Alcohol:
❑None
❑ Less than 1 drink/day
❑ 1-2 drinks daily
❑ 3 or more drinks daily

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 over the age of 65)?
Please provide the approximate number in the space provided
_____

Have you received your flu vaccination?
❑ Yes ❑ No

What year?

Have you received your pneumonia vaccination?
❑ Yes ❑ No

REVIEW OF SYSTEMS **History or current problem with any of the following?** (Please check all that apply)

Problems with bleeding	❑ Yes ❑ No	Night Sweats	❑ Yes ❑ No	Blood thinners	❑ Yes ❑ No
Problems with healing	❑ Yes ❑ No	Rash/Hives	❑ Yes ❑ No	Defibrillator	❑ Yes ❑ No
Problems with scarring (hypertrophic or keloid)	❑ Yes ❑ No	Seizures	❑ Yes ❑ No	MRSA	❑ Yes ❑ No
Abdominal Pain	❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No
Anxiety	❑ Yes ❑ No	Sleeplessness	❑ Yes ❑ No	Currently Pregnant or planning a pregnancy	❑ Yes ❑ No
Bloody Stool	❑ Yes ❑ No	Sore Throat	❑ Yes ❑ No	Premedication prior to procedures	❑ Yes ❑ No
Bloody Urine	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No	Rapid heartbeat with epinephrine	❑ Yes ❑ No
Blurry Vision	❑ Yes ❑ No	Unintentional Weight loss	❑ Yes ❑ No	Ebola Risk: Fever >+100.4	❑ Yes ❑ No
Chest Pain	❑ Yes ❑ No	Vaginal Candidiasis	❑ Yes ❑ No	West Africa: Travel or contact	❑ Yes ❑ No
Cough	❑ Yes ❑ No	Wheezing	❑ Yes ❑ No	Ebola Risk: contact w/ebola patient without Proper protective equipment within the last 21 days	❑ Yes ❑ No
Depression	❑ Yes ❑ No	Red Eye	❑ Yes ❑ No		
Dizziness	❑ Yes ❑ No	Tearing	❑ Yes ❑ No		
Fever or Chills	❑ Yes ❑ No	Eye Pain	❑ Yes ❑ No		
Grey Discoloration of Skin	❑ Yes ❑ No	Uncontrolled Blood Pressure	❑ Yes ❑ No		
Hay Fever	❑ Yes ❑ No	Elevated Blood Sugar	❑ Yes ❑ No		
Headaches	❑ Yes ❑ No	Allergy to adhesive	❑ Yes ❑ No		
Immunosuppression	❑ Yes ❑ No	Allergy to Lidocaine	❑ Yes ❑ No	Ebola Risk: Headaches, weakness, muscle pain Vomiting, diarrhea, abdominal pain, and/or Hemorrhage	❑ Yes ❑ No
Joint Aches (if yes, indicate year_____)	❑ Yes ❑ No	Allergy to topical antiobiotic ointments	❑ Yes ❑ No		
Menstrual Changes	❑ Yes ❑ No	Artificial heart valves	❑ Yes ❑ No	Prostate Medications	❑ Yes ❑ No
Muscle Weakness	❑ Yes ❑ No	Artificial joints in the last 2 yrs	❑ Yes ❑ No	Transplant	❑ Yes ❑ No
Neck Stiffness	❑ Yes ❑ No	Blood thinners	❑ Yes ❑ No		

Signature of Responsible Party/Date _____