Grosse Pointe Dermatology Associates, P.C.

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Name _____ DOB _____ Todays Date _____

Address:_____

Home Phone #:_____ Cell Phone #: _____

May we leave a message if we receive your voicemail? YES or NO (if YES please indicate what number we may leave a message at) _____

E-Mail: _____@_____.com

Top 3 reasons for visit today, include duration of problem:

_____
_____
_____

Past Medical History. Please circle which apply to you.

Anxiety/ Arthritis/ Asthma/ Atrial Fibrillation (AFib)/ Bone Marrow Transplant/

BPH/ Breast Cancer/ Colon Cancer/ COPD/ Coronary Artery Disease/ Defibrillator/

Depression/ Diabetes/ End Stage Renal Disease/ GERD/ Hearing Loss/ Hepatitis/

Hypertension/ HIV/AIDS/ Hypercholesterolemia/ Hyperthyroidism/ Hypothyroidism/

Leukemia/ Lung Cancer/ Lymphoma/ Pacemaker/ Prostate Cancer/ Radiation Treatment

Seizures/ Stroke

Other :_____ NONE

Past Surgical History:_____

Skin Medical History: Please circle which apply to you.

Acne Actinic Keratoses Basal Cell Carcinoma Blistering Sunburns Dry Skin Eczema

Flaking or Itchy Scalp Hay fever/allergies Melanoma Poison Ivy Precancerous Moles

Psoriasis Squamous Cell Carcinoma NONE Other:_____

Do you use sunscreen? Yes No SPF used: 15 30 45 100

Do you use a tanning booth? Yes No

Family History of Melanoma: Yes, if so which member _____ No

Medications: Please list medication names, strength and start date. NO MEDICATIONS

_____
_____
_____
_____

Allergies to medications, please list allergies and syndromes: NO ALLERGIES

_____

Smoking status: Never Former Current

Alcohol Intake: Never < 1 drink a day 1-2 drinks per day > 3 drinks per day

Driving Status: Drives in the Daytime Drive at Night

Family History of Heart Disease: Yes, if so which member _____ No

Family History of Non-Melanoma Skin Cancer: Yes, if so which member _____ No

Primary Care Providers Name: _____ Phone #: _____

Location _____ Last Visit to PCP:_____

Have you been vaccinated for pneumonia? Yes No

Have you been vaccinated for the flu this year? Yes No

Pharmacy Name:_____ Phone #: _____

Address_____ City/zip code:_____

Review of Systems: circle what applies to you- Problems with bleeding

Problems with healing/ Problems with scar/ Rash/ Seizures/ Pacemaker/

Immunosuppression/ Hay Fever/ Chest Pain/ Fever or Chills/ Night Sweats/

Unintentional Weight loss/ Thyroid Problems/ Sore Throat/ Blurry Vision/ Cough/

Abdominal Pain/ Bloody Stool/ Bloody Urine/ Joint Aches/ Muscle Weakness/

Neck Stiffness/ Headaches/ Shortness of Breath/ Anxiety/ Depression/

Allergic to Adhesive/ Allergy to lidocaine/ Allergy to Topical Antibiotic Ointment/

Artificial Joints within past 2 years/ Artificial heart valve/ blood thinners/ MRSA/

Premedication prior to Procedures/ Rapid heartbeat with Epinephrine/ Pregnancy/ Planning on Pregnancy

I give you permission to discuss my protected health information with:
(Please list the name(s) of the person(s) you will allow our office to discuss your protected health information with. If no names are given and a person calls on your behalf without being listed on this form, we will NOT provide them with any information about yourself, including upcoming appointment times. Please add as many personal names as you need, you do not need to add physicians in this section.)

_____ _____

Name & Relationship Name & Relationship

I give Grosse Pointe Dermatology permission to contact my pharmacy for my prescription information:

Pharmacy Name and phone number

_____ _____

Please sign this line **Date**