NELSON DERMATOLOGY

Name:_____ **Date:**_____
Address:_____
City:_____ **State:**_____ **Zip:**_____
DOB:_____ **Occupation:**_____
Phone:_____ **Cell Phone:** _____ **SSN:**_____
Email:_____
Marital Status:_____
Insurance Name:_____ **Subscriber Name:**_____
Subscriber SSN:_____ **Subscriber DOB:**_____
Person to Contact in Emergency:_____
Primary Care Physician:_____
Primary Care Physician Address:_____

Preferred Pharmacy:
Name:_____ Phone:_____
Street:_____ Zipcode:_____

Medications: (Please list all current medications or provide a list to front desk)
☐ None
_____
_____
_____

Allergies: (Please enter all MEDICATION allergies)
☐ No Known Drug Allergies
_____
_____

Social History: (Please answer all questions)

Cigarette Smoking:
Never smoked
Quit: former smoker
Current: Smokes less than daily
Current: Smokes daily

Language:
English
Spanish
Other:_____

Alcohol Screening Question: (must be answered):
How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?
0 1 2 3 4 5 6 7 8 9 10

Pneumonia Vaccination Status (For patients 65 and older):
Have you received a pneumonia vaccination (typically given as one shot by your PCP at visit around your 65th birthday)? Yes No

Do you have a health care proxy in the event you are unable to make your own medical decisions?: Yes No
Name and Phone Number of Proxy:_____

Please complete both sides of this information sheet

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Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Past Medical History: (please circle all that apply)
None
Anxiety disorder
Arthritis
Asthma
Atrial fibrillation
Benign prostatic hyperplasia
Cerebrovascular accident (Stroke)
Chronic obstructive lung disease
Coronary arteriosclerosis
Depressive disorder
Diabetes mellitus
Disease caused by 2019-nCoV (COVID19)
Elevated blood pressure
End-stage renal disease
Epilepsy
Gastroesophageal reflux disease
H/O: hypertension
Hearing loss
Human immunodeficiency virus infection
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Inflammatory disease of liver
Leukemia
Malignant lymphoma
Malignant tumor of lung
Malignant tumor of breast
Malignant tumor of colon
Malignant tumor of prostate
Radiation therapy treatment management
Transplantation of bone marrow
Other _____

Skin Disease History: (please circle all that apply)
None
Acne
Actinic Keratosis
Asteatosis cutis (Dry Skin)
Basal Cell Skin Cancer
Contact dermatitis due to poison ivy
Dysplastic nevus of skin
Eczema
H/O: asthma
H/O: hay fever
Malignant melanoma
Pruritus of scalp (Itchy scalp)
Psoriasis
Squamous cell carcinoma
Sunburn of second degree
Other_____

Please complete both sides of this information sheet