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PATIENT INFORMATION SHEET

DEMOGRAPHICS

DATE / /

Patient Name _____ Date of Birth / /

Referring Physician _____ Preferred Pharmacy _____

Primary Care Physician _____ City, State

Your email address _____

CHIEF COMPLAINT

What is your chief concern for today's visit? _____

Regarding your concern:

Where is it located? _____

How long has it been present? _____

Does it bleed? ☐ YES ☐ NO

Does it itch? ☐ YES ☐ NO Is it worse at night? ☐ YES ☐ NO

What treatments have you tried? _____

What makes it better? _____

What makes it worse? _____

Any other concerning symptoms? _____

PAST MEDICAL HISTORY

Select any of the following medical conditions that you currently have or have had in the past:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hypertrophy (BPH)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Coronary Artery Disease (CAD)
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Kidney Disease (ESRD)
- ☐ Gastroesophageal Reflux Disease (GERD)
- ☐ Other: _____
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia/Lymphoma
- ☐ Lung Cancer
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None

PAST SURGERIES

- ☐ Appendix (Appendectomy)
- ☐ Breast Mastectomy: ☐ RIGHT ☐ LEFT
- ☐ Colon (Colectomy)
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery (CABG)
- ☐ Heart: Valve Replacement: ☐Mechanical ☐Biological
- ☐ Heart: ☐ Pacemaker ☐ Defibrillator
- ☐ Hip Replacement ☐ RIGHT ☐ LEFT Year _____
- ☐ Knee Replacement ☐ RIGHT ☐ LEFT Year _____
- ☐ Kidney (Nephrectomy)
- ☐ Kidney transplant
- ☐ Ovary (Oophorectomy)
- ☐ Prostate (Prostatectomy)
- ☐ Spleen (Splenectomy)
- ☐ Uterus (Hysterectomy)
- ☐ Other: _____

SKIN DISEASE HISTORY

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Bleeding problems
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Cold Sores
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Problems with scarring (keloids)
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Trouble Healing
- ☐ Other: _____

Do you wear sunblock? ☐ YES ☐ NO SPF _____

Do you tan in a tanning salon? ☐ YES ☐ NO ☐ Previously

Do you have a family history of melanoma? ☐ YES ☐ NO

If yes, which relative? _____

MEDICATIONS: MEDICATIONS, SUPPLEMENTS, AND OVER-THE-COUNTERS - INCLUDE ROUTE/DOSAGE/FREQUENCY

_____ _____

_____ _____

_____ _____

ALLERGIES

Allergies to medications: _____

Allergy to adhesive bandage? ☐ YES ☐ NO

Allergy to topical antibiotic ointments? ☐ YES ☐ NO

Difficulty with systemic antibiotics? ☐ YES ☐ NO If yes: ☐ GI upset ☐ yeast infections

SOCIAL HISTORY

Do you smoke? ☐ YES ☐ NO ☐ Former

Do you drink alcohol? ☐ Daily ☐ Occasionally ☐ Never

What is/was your occupation? _____

Patient Signature _____ Date ___/___/___

Provider Signature _____ Date ___/___/___