Southern Marin Dermatology

Date:_____

WELCOME!

Full Legal Name: _____

Nickname: _____ Date of Birth: _____

Gender: ☐ F ☐ M Height: _____ Weight: _____

Home Street Address: _____

City:_____ State:_____Zip:_____

Home phone: _____ Cell: _____ Work: _____

Email: _____Preferred method of contact: _____

Occupation or School: _____ Employer:_____

Work address: _____

Marital Status: Married Domestic Partner Widowed Divorced Separated Single Other

Spouse/Partner Name: _____

Spouse's Employer: _____ Spouse's phone: _____

For children under 18:

Parent/Guardian Name: _____ Relationship to patient: _____

Preferred phone number: _____ ☐ cell ☐ home ☐ other_____

Other Parent or Guardian: _____ Relationship to patient: _____

Preferred phone number: _____ ☐ cell ☐ home ☐ other_____

In case of emergency, we may contact:

☐ Spouse/partner listed above ☐ Parent/Guardian(s) listed above ☐ Other (list below):

Name: _____ Phone number: _____

Relationship to patient: _____

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Name:_____Date: _____

Insurance Information ☐ I do not have medical insurance

If you do NOT have your insurance card with you, please fill out the information below:

Name of Insurance Company: _____

Insurance ID number: _____ Group number: _____

If you are not the primary cardholder, please complete information below:

Subscriber's name: _____ Date of Birth: _____

Subscriber's relationship to patient: ☐ Spouse/partner ☐ Guardian/Parent ☐ Other:_____

Billing address: _____ Contact phone: _____

(If different from above) (If different from above)

Preferred language: ☐ English ☐ Other: _____

Race/Ethnicity (optional):

☐ Alaska native ☐ American Indian ☐ Asian ☐ African or African-American
☐ Latin/Hispanic ☐ Native Hawaiian/Pacific Islander ☐ Caucasian/White
☐ Middle Eastern ☐ Other: _____ ☐ Prefer not to answer

Have you seen Dr. Fardin or Dr. Smith before? ☐ Yes ☐ No

If yes, where and when (approximately)? _____

How did you hear about our office?

☐ I was referred by my Doctor/Health Care Practitioner: _____
☐ Online: ☐ Website ☐ Yelp ☐ Zocdoc ☐ Google
☐ Other: _____

Preferred pharmacy:

Name:_____

Location/Address: _____

Primary Care Physician:

Name: _____

Phone: _____ Fax: _____

Street Address: _____

City:_____ State:_____Zip:_____

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Name:_____Date: _____

HISTORY FORM

What brings you to the office today? _____

_____

Have you been treated for this before? ☐ Yes ☐ No

MEDICAL HISTORY

*Select any conditions you **currently** have:*

___ Anxiety
___ Arthritis type: _____
___ Asthma
___ Atrial Fibrillation
___ BPH/Enlarged Prostate
___ Bone Marrow Transplantation
___ Breast Cancer
___ Colon Cancer
___ COPD/Emphysema
___ Coronary Artery Disease
___ Depression
___ Diabetes
___ End Stage Renal Disease
___ GERD/Acid Reflux
___ Hearing Loss
___ Hepatitis
___ Hypertension
___ HIV / AIDS
___ Hypercholesterolemia
___ Hyperthyroidism
___ Hypothyroidism
___ Leukemia
___ Lung Cancer
___ Lupus
___ Lymphoma
___ Pacemaker
___ Prostate Cancer
___ Radiation Treatment
___ Seizures
___ Stroke
Other _____
_____
_____
_____

☐ **None**

PAST SURGICAL HISTORY

Please indicate any surgeries & date(s):

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast : Mastectomy (Right, Left, Both)
Breast : Lumpectomy (Right, Left, Both)
Breast Biopsy
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: Inflammatory Bowel Disease
Gallbladder (Cholecystectomy)
Heart: Angioplasty (PTCA)
Heart: Coronary Artery Bypass Surgery
Heart: Defibrillator
Heart: Biological Valve Replacement
Heart: Mechanical Valve Replacement
Heart: Pacemaker
Heart: Transplant
Knee Replacement: (Right, Left, Both)
Kidney Biopsy
Kidney Removal (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovarian Removed: Cancer
Prostate (Prostatectomy) : Prostate Cancer
Prostate Biopsy
Spleen Removed (Splenectomy)
Testicles (Orchidectomy)
Uterus (Hysterectomy): Fibroids
Uterus (Hysterectomy): Uterine Cancer
Other:_____
_____
_____
_____
_____

☐ **No Surgeries**

☐ **I take antibiotics before surgical procedures or before visiting the dentist**

SKIN DISEASE HISTORY

___ Acne
___ Actinic Keratoses (precancers)
___ Basal Cell Skin Cancer
___ Blistering Sunburns
___ Dry Skin
___ Eczema
___ Flaking or Itchy Scalp
___ Hay Fever / Allergies
___ Melanoma
___ MRSA infection
___ Poison Ivy
___ Precancerous or Dysplastic Moles
___ Psoriasis
___ Squamous Cell Skin Cancer
___ Other Skin Biopsy
___ **NONE OF THE ABOVE**

Other:_____
_____
_____

Do you wear Sunscreen?
___Yes ___No

What SPF? _____
Every day? ___ Yes ___ No

Do you tan in a tanning salon?
___Yes ___ No

FAMILY HISTORY

Do you have a family history of Melanoma?
___Yes ___No ___ Not sure
Which relative? _____

Do you have a family history of Basal cell or Squamous cell skin cancer?
__ BCC __SCC

Do you have a family history of Pre-cancerous moles? __ Yes __ No

Any other family history:_____
_____
_____
_____

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Name:_____Date: _____

Medications

Please list all of your current medications and doses:
(Prescriptions, over-the-counter meds, vitamins and herbal supplements)

_____
_____
_____
_____
_____

Are you regularly or sometimes taking any medicines that can thin the blood? ☐ Yes ☐ No
(Such as Aspirin, Ibuprofen, Motrin, Naprosyn, Aleve, Coumadin, Plavix, etc.)

Allergies List your medication or food allergies below and the reaction you get with each:

☐ I have NO known drug allergies
☐ Allergic to tape/adhesive ☐ Allergic to Neosporin/Antibiotic ointment
☐ Allergic to lidocaine ☐ Rapid heart rate with epinephrine

Medication/Food: Reaction:

_____
_____
_____
_____
_____

Social History

___ Not sexually active
___ Sexually active with one partner
___ Sexually active with more than 1 partner
___ Same gender partner

___ Do not drink alcoholic beverages
___ Less than 1 drink a day
___ 1-2 drinks a day
___ 3 or more drinks a day

___ Never smoker
___ Current every day smoker ____packs/day
___ Current occasional smoker
___ Former smoker

Women: Are you currently pregnant? ☐ Yes ☐ No
Trying to get pregnant? ☐ Yes ☐ No
Nursing? ☐ Yes ☐ No

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REVIEW OF SYSTEMS

Indicate any that are ***recent or current*** symptoms:

SKIN/HAIR/NAIL
___ *Problems with bleeding*
___ *Problems with healing*
___ *Problems with scarring (keloid/hypertrophic)*
___ *Rash*
___ *Itching*
___ *Moles/Growths*
___ *Acne*
___ *Changes in nails*
___ *Hair loss*
___ *Other Concerns*

ALLERGIC/IMMUNOLOGIC
___ *Immunosuppression*
___ *Hay Fever*

CARDIAC
___ *Chest pain*
___ *Irregular Heartbeat*

GENERAL/CONSTITUTIONAL
___ *Fever or Chills*
___ *Night sweats*
___ *Unintentional weight loss*

ENDOCRINE
___ *Thyroid problems*

EAR/NOSE/THROAT
___ *Sore throat*

EYE
___ *Blurry vision*

DIGESTIVE
___ *Abdominal pain*
___ *Heartburn*
___ *Blood in stools*

GENITOURINARY
___ *Blood in urine*

MUSCULOSKELETAL
___ *Joint pain or aches*
___ *Muscle weakness*
___ *Neck stiffness*

NEUROLOGICAL
___ *Headaches*
___ *Dizziness*
___ *Seizures*

RESPIRATORY
___ *Cough*
___ *Shortness of breath*
___ *Wheezing*

PSYCHIATRIC
___ *Anxiety*
___ *Depression*

HEMATOLOGIC / LYMPHATIC
___ *Bleed or bruise easily*
___ *Blood clots*
___ *Swollen glands*
___ *Swelling of extremities*

☐ ***NONE OF THE ABOVE***

OTHER:
_____
_____
_____
_____

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