SMD Southern Marin Dermatology

Date:______________

WELCOME TO SMD!

Full Legal Name: ____

I prefer to be called: ________________________Date of Birth: ________________

Gender: ☐ F ☐ M Height: __________ Weight: ______________

Home Street Address: ____

City:____________________________ State:__________Zip:____________

Home phone: ______________ Mobile: ________________ Work: ____________

Personal email: ______________________________Preferred phone:____________

☐ My mailing address is different from above: ________________State: ________Zip:________

Occupation or School: _______________________Employer:__________________

Work address: ____

Marital Status: Married Domestic Partner Widowed Divorced Separated Engaged Single

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, SMD may contact:

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

Name: ________________Phone number: __________ Relationship to patient: __________

Insurance Information: ☐ I do NOT have medical insurance

Name of Insurance Company: ____

Preferred language: ☐ English ☐ Other: ______________

Ethnicity: (optional) ☐ Hispanic ☐ Non-Hispanic

Race: (optional)

☐ Asian/South Asian ☐ African or African-American ☐ Caucasian/White ☐ Middle Eastern

☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ __________

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Name:____Date: ____________________

Have you seen Dr. Fardin, Dr. Smith or Dr. Westphal in another office? ☐ Yes ☐ No
Where and when (approximately)? ____

How did you hear about our office?

☐ I was referred by my Doctor/Health Care Practitioner: ______________________________

☐ Online: ☐ Website ☐ Yelp ☐ Google ☐ SMMC ☐ Nextdoor ☐ Other:________________

Preferred pharmacy:

Name:____

Location/Address: ____

Primary Care Physician:

Name: ____________________________________Phone:________________________

Address: ____

City:_______________________________ State:______________Zip:________________

Medications:

Please list or attach a list of all your current **medications, doses and how often** you take each:
(Prescriptions, hormonal patches/implants/rings/shots, over-the-counter meds, vitamins and herbal supplements)

____

____

____

____

____

Allergies:

Please list your medication/food allergies below and the reaction you get with each:

☐ **I have NO known drug allergies**

☐ Allergic to Latex

☐ Allergic to tape/adhesive

☐ Allergic to lidocaine/anesthetics

☐ Allergic to Neosporin/Bacitracin/Antibiotic ointment

☐ Fast heart rate with low doses of epinephrine

Medication/Food: Reaction:

____

____

____

Sexual History:

___ Not sexually active

___ Sexually active with one partner

___ Sexually active > 1 partner

___ Homosexual partner

Alcohol Use:

___ None

___ Less than 1 drink per day

___ 1-4 drinks per day

___ 5 or more drinks per day

Smoking:

___ Never smoker

___ Every day cigarette smoker

___ Every day other tobacco user

___ Former smoker ___Rare smoker

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Southern Marin Dermatology

Name:______________________________ Date: ______________

MEDICAL/SURGICAL HISTORY

What brings you to the office today?______________________________

____

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

MEDICAL HISTORY

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

☐ None

___ 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: ______________________________

____

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____

WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No
Trying to get pregnant? ☐ Yes ☐ No
Nursing? ☐ Yes ☐ No
If applicable, please list any contraception or hormones being used:________

____

PAST SURGICAL HISTORY

Please indicate any surgeries & date(s):

☐ No Surgeries

☐ **I must take antibiotics before surgical procedures or dental cleaning**

Appendix (Appendectomy)
Bladder (Cystectomy)
Breast : Mastectomy (Right, Left, Both)
Breast : Lumpectomy (Right, Left, Both)
Breast Biopsy (benign)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Surgery
Colectomy: Diverticulitis/Other
Colectomy: Inflammatory Bowel Disease
Gallbladder (Cholecystectomy)
Heart: Angioplasty (PTCA) or Stent
Heart: Coronary Artery Bypass Surgery
Heart: Defibrillator
Heart: Biological Valve Replacement
Heart: Mechanical Valve Replacement
Heart: Pacemaker
Heart: Transplant
Knee Surgery
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)
Testicle(s) removed (Orchidectomy)
Uterus surgery: Fibroids or Other
Uterus removed (Hysterectomy): Uterine Cancer
Uterus removed (Hysterectomy): Other reason

Other:______________________________

____

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____

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 Oak/Ivy
___ Precancerous or Dysplastic Moles
___ Psoriasis
___ Squamous Cell Skin Cancer
___ Other Skin Biopsy
___ NONE OF THE ABOVE

Other:______________________________

____

Do you regularly:

wear sunscreen? ☐ Yes ☐ No SPF: ______
wear hats? ☐ Yes ☐ No
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 skin cancer (BCC) ? ☐ Yes ☐ No
Squamous cell skin cancer (SCC)? ☐ Yes ☐ No
Pre-cancerous moles? ☐ Yes ☐ No

Any other family history:______________

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____

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Name:____Date: _________________________

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*

Are you regularly or sometimes taking any medicines or supplements that can thin the blood/cause bruising? ☐ Yes ☐ No
If Yes, Please circle:

Aspirin, Ibuprofen, Motrin, Naprosyn, Aleve, Coumadin, Plavix, Lovenox, Xarelto, Eliquis, Fish oils, Vitamin E, Omega 3 fatty acids, ginkgo biloba, garlic, licorice, CoQ10, cayenne, other:____________

Age 65 and Older ONLY:

Medicare Required Merit-based Incentive Payment System (MIPS) Questions:

Do you have a living will? ☐ Yes ☐ No
Who is your health care proxy/designee?____________________________________ Phone:____________________
☐ I wish to have full cardiopulmonary resuscitation efforts (I am FULL CODE)
☐ I have a DNR Order (DO NOT resuscitate) ☐ I have a DNI order (DO NOT intubate)
Have you had the PNEUMONIA vaccine? ☐ Yes ☐ No If no, why not? _____________________________
Please list how many times in the past year have you had:
MEN: 5 or more alcoholic drinks __________ WOMEN: 4 or more alcoholic drinks ___________

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