Dermatology Specialists of North Florida, P.A.
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Patient Name: ____________________
Address: ____________________
Home Phone: ____________________
Cell Phone: ____________________
Date of Birth: _____/_____/__________ **Social Security Number:** _____/_____/__________
Marital Status: ________________
Email Address: ____________________
Employer Name: ____________________
Employer Phone: ____________________

Primary Insurance: ____________________
Subscriber ID: ____________________ **Group Number:** ____________________
***** PLEASE COMPLETE THIS SECTION IF OTHER THAN PATIENT *****
Subscriber Name: ____________________
Relation to Patient: ____________________
Subscriber Date of Birth: _____/_____/__________
Subscriber SSN: _____/_____/__________

Secondary Insurance: ____________________
Subscriber ID: ____________________ **Group Number:** ____________________
***** PLEASE COMPLETE THIS SECTION IF OTHER THAN PATIENT *****
Subscriber Name: ____________________
Relation to Patient: ____________________
Subscriber Date of Birth: _____/_____/__________
Subscriber SSN: _____/_____/__________

Family Physician: ____________________ **Referring MD**: ____________________

Emergency Contact: ____________________ **Number:** ____________________
Relationship: ____________________

Pharmacy Name: ____________________ **Number:** ____________________

Current Medications: ____________________
____

Recent Surgeries (past 10yrs): ____________________
____

Drug Allergies: ____________________
____

Patient Signature: ____________________ **Date:** _____/_____/_____

Dermatologic History **Patient Initials: __________**

Skin allergies	O	Yes	O	No
Eczema	O	Yes	O	No
Psoriasis	O	Yes	O	No
Melanoma	O	Yes	O	No
Mole(s), dysplastic or abnormal	O	Yes	O	No
Actinic keratoses	O	Yes	O	No
Squamous or Basal cell carcinoma	O	Yes	O	No
History of lymphoma	O	Yes	O	No
History of leukemia	O	Yes	O	No
Hives	O	Yes	O	No
History of lupus erythematosus	O	Yes	O	No
Sun sensitivity	O	Yes	O	No
Regular Sunscreen use:	O	Yes	O	No

Surgical History

Melanoma	O	Yes	O	No
Squamous cell carcinoma	O	Yes	O	No
Basal cell carcinoma	O	Yes	O	No
Lipoma	O	Yes	O	No

Have you been instructed to take any prophylactic antibiotics prior to surgical procedure?

O Yes O No

Have you ever had any reaction to a local anesthetic?

O Yes O No

Do you have any other disease, condition or problems that we should know about?

O Yes O No

Are you a O current smoker O current every day smoker O current some day smoker

O smoker current status unknown O former smoker

O nonsmoker O unknown if ever smoked

Review of Systems **Patient Initials: ___________**

Bronchitis / Asthma	O	Yes	O	No
Emphysema	O	Yes	O	No
Chronic or AM Cough	O	Yes	O	No
Hay Fever	O	Yes	O	No
High Blood Pressure	O	Yes	O	No
Chest Pain/MI/TIA	O	Yes	O	No
Heart Murmur / Valve Disease	O	Yes	O	No
Irregular or Fast Heart Beat	O	Yes	O	No
Pacemaker	O	Yes	O	No
Do you bleed easily?	O	Yes	O	No
Have you ever had a blood transfusion?	O	Yes	O	No
Diabetes	O	Yes	O	No
Thyroid Disease	O	Yes	O	No
Kidney / Bladder Problems	O	Yes	O	No
Stomach / Bowel Problems	O	Yes	O	No
Hepatitis / Yellow Jaundice	O	Yes	O	No
Convulsions / Epilepsy / Seizures	O	Yes	O	No
Glaucoma	O	Yes	O	No
AIDS or HIV Exposure	O	Yes	O	No
Phlebitis	O	Yes	O	No
Joint Deformity	O	Yes	O	No
(Women) Are you pregnant?	O	Yes	O	No
Alcohol Use	O	Yes	O	No

How often did you have 6 or more drinks on one occasion in the past year?

O Never O Monthly O Less than monthly O Weekly O Daily or almost daily