NELSON DERMATOLOGY

Name:_____ **Date:**_____
Address:_____
City:_____ **State:**_____ **Zip:**_____
DOB:_____ **Occupation:**_____
Phone:_____ **Cell Phone:** _____ **SSN:**_____
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 circle one)

Cigarette Smoking:	Alcohol Use:	Language:
Never smoked	YES	English
Quit: former smoker	NO	Spanish
Current: Smokes less than daily		Other:_____
Current: Smokes daily		

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: _____

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Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Bone Marrow Transplantation
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing loss
Hepatitis
Hypertension
HIV / AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung cancer
Lymphoma
Prostate cancer
Radiation treatment
Seizures
Stroke
Other _____
None

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever / Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous cell skin cancer
Other_____
None

Do you wear Sunscreen? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No