FAIR WINDS
DERMATOLOGY

PLEASE BRING CURRENT GOVERNMENT ISSUED PICTURE IDENTIFICATION AND INSURANCE CARD(S) AT TIME OF YOUR APPOINTMENT. PAPERWORK NEEDS TO BE FILLED OUT & RECEIVED BY THE APPOINTMENT TIME OR WE MAY NEED TO RESCHEDULE YOUR APPOINTMENT.

DATE _____

PATIENT INFORMATION:

FIRST NAME _____ M.I._____ LAST NAME _____ PREFERRED NAME _____

PREFERRED PRONOUNS:_____ MARITAL STATUS _____ SS# _____ DOB _____ SEX _____

LANGUAGE _____ PREFER NOT TO ANSWER _____

ETHNICITY: Hispanic _____ Not Hispanic _____ PREFER NOT TO ANSWER _____

RACE _____ PREFER NOT TO ANSWER _____

REFERRED BY _____ PRIMARY CARE PHYSICIAN _____

EMPLOYER _____ OCCUPATION _____ EMPLOYER'S PHONE _____

PATIENT CONTACT INFORMATION:

HOME PHONE _____ CELL PHONE _____ WORK _____

Are you comfortable securely communicating with our clinic via text message? Yes_____ No _____

May we leave personal medical information on your answering machine or cell phone? Yes_____ No _____

E-MAIL _____ PREFERRED METHOD OF CONTACT _____

PHYSICAL ADDRESS _____ CITY _____ ZIP _____

MAILING ADDRESS (IF DIFFERENT)_____ CITY _____ ZIP _____

RESPONSIBLE PARTY/GUARDIAN (IF APPLICABLE)_____ DOB _____ RELATIONSHIP _____

****Do you have a healthcare proxy in the event you are unable to make your own medical decisions? Yes _____ No ___**

If yes, who? _____ ** Do you have a living will? Yes _____ No ___

EMERGENCY CONTACTS:

NAME _____ RELATIONSHIP _____ PHONE _____

WHO IS IT OK TO DISCUSS MEDICAL INFORMATION WITH?

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

PRIMARY INSURANCE COMPANY _____ ID# _____

SUBSCRIBER'S NAME _____ DOB _____ Relationship _____

SUBSCRIBER'S MAILING ADDRESS (IF DIFFERENT) _____ CITY _____ ZIP _____

SECONDARY INSURANCE COMPANY _____ ID# _____

SUBSCRIBER'S NAME _____ DOB _____ Relationship _____

SUBSCRIBER'S MAILING ADDRESS (IF DIFFERENT) _____ CITY _____ ZIP _____

SEPARATE PRESCRIPTION INSURANCE _____

Electronic Prescription Download

The privacy of your personal health information contained in all your prescriptions is protected by a federal law, HIPAA, and state laws. Your personal health information can only be shared for the purpose of providing you with clinical care. E-prescriptions meet this requirement. I also authorize Fair Winds Dermatology to release my medical information to another physician, hospital, pharmacy, or medical care facility as needed to facilitate treatment. I furthermore will allow my pharmacy to supply verification of benefits. ** **If you require a mail order pharmacy, you MUST provide us with a fax number.**

Pharmacy _____ Location _____

MEDICAL HISTORY FORM

*****IMPORTANT: PLEASE ANSWER AS COMPLETE AS POSSIBLE*****

AGE_____ WEIGHT _____lbs. HEIGHT _____ft._____in.

*****Have you ever received a pneumonia shot? Y/N**

MEDICAL HISTORY (Illnesses you have or you had in the past, check all that apply)

☐ Anxiety	☐ Colon Cancer	☐ Hepatitis A B C (Circle)	☐ Lymphoma
☐ Arthritis	☐ COPD	☐ Liver Disease	☐ Organ Transplant
☐ Asthma	☐ Coronary Artery Disease	☐ Hypertension	☐ Pacemaker
☐ Atrial Fibrillation	☐ Depression	☐ HIV / AIDS	☐ Prostate Cancer
☐ Autoimmune Disease	☐ Diabetes	☐ High Cholesterol	☐ Positive TB Skin Test (PPD)
	☐ End Stage Renal Disease	☐ Hyperthyroidism	☐ Radiation Treatment
☐ Bone Marrow Transplantation	☐ GERD	☐ Hypothyroidism	☐ Epilepsy
	☐ Hearing Loss	☐ Leukemia	☐ Stroke
☐ Breast Cancer	☐ Heart Valves	☐ Lung Cancer	☐ Other _____

SKIN DISEASE (Check all that apply)

☐ Acne	☐ Blistering Sunburns	☐ Hay Fever/Allergies	☐ Dysplastic (atypical) Moles
☐ Actinic Keratosis	☐ Dry Skin	☐ Keloids	☐ Psoriasis
☐ Poison Ivy/Oak	☐ Eczema	☐ Melanoma	☐ Squamous Cell Skin Cancer
☐ Basal Cell Skin Cancer	☐ Flaking or Itchy Scalp		☐ Tanning bed use (past or present)

LIST THE MEDICATIONS YOU ARE TAKING: ☐ **NONE**

_____ _____

_____ _____

_____ _____

LIST PRIOR SURGERIES AND THE YEAR COMPLETED:

_____ _____

_____ _____

ALLERGY TO MEDICATIONS: ☐ **NO KNOWN DRUG ALLERGIES**

_____ _____

FAMILY HISTORY (Circle all that apply and list relationship)

Melanoma Who?	Eczema	Psoriasis	Other Skin Changes	Genetic disease

SOCIAL HISTORY:

Smoking Status: ☐Everyday ☐Somedays ☐Former smoker ☐ Never

Start:	Quit:	Number of Packs:	Total Years Smoking?

Do you drink alcohol? ☐YES ☐NO How many drinks per day? _____

Within the last 2-3 days, have you experienced any of the following symptoms?

Skin

__ Rash
__ Lumps
__ Itching
__ Dryness
__ Color changes
__ Hair and nail changes
__ Problems with healing
__ Problems with scarring (hypertrophic or keloid)

Immunologic

__ Hepatitis
__ HIV positive
__ Hay fever
__ Immunosuppression

Hematologic/Lymphatic

__ Problems with bleeding

Constitutional/symptom

__ Fever or chills
__ Fatigue
__ Unintentional weight loss

Musculoskeletal

__ Joint aches
__ Muscle weakness
__ Swollen joints

Cardiovascular

__ Chest pain
__ Edema

Endocrine

__ Thyroid problems

ENT and Mouth

__ Sore throat

Eyes

__ Blurry vision

Gastrointestinal (G.I)

__ Abdominal pain
__ Bloody stool
__ Bloody urine

Neurological

__ Headaches
__ Seizures

Respiratory

__ Cough
__ Shortness of breath
__ Wheezing

Psychiatric

__ Anxiety
__ Depression

Other: _____

Please mark if you have any of the following symptoms/conditions:

__ Immunodeficiency
__ Allergy to adhesives
__ Allergy to lidocaine
__ Allergy to topical antibiotic ointments
__ Artificial heart valve
__ Artificial joints withing the past two years
__ Taking blood thinners – including aspirin or fish oil
__ Defibrillator
__ MRSA
__ Pacemaker
__ Premedication prior to procedures
__ Rapid heartbeat with epinephrine
__ Pregnancy or planning a pregnancy

Signature: _____ Date:_____