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 ___

Which statement best reflects your wishes on advanced care recommendations?

___ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life

___ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life

___ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made

EMERGENCY CONTACTS:

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 _____

PERMISSION FOR PATIENT HEALTH INFORMATION (PHI) COMMUNICATIONS

I permit Fair Winds Dermatology, their physicians, medical assistants, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care:

(List family members/friends and state the person's relationship to the patient below).

NAME	DATE OF BIRTH	PHONE NUMBER	RELATIONSHIP
1.			
2.			
3.			
4.			

This authorization will expire (please check one):

_____ 1 year from the date the signed

_____ 3 years from date the signed

If, at any time, I do not want verbal discussion to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting Fair Winds Dermatology.

This is a legal document and by signing, you agree that you understand and accept the terms on this form.

_____ _____

Patient Name (Printed) Patient Date of Birth

_____ _____

Patient Signature Date

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 ***Did you have a COVID shot within the last year? 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	☐ Urinary incontinence	☐ 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:_____