GRAND ISLAND
Dermatology
INNOVATIVE SKIN CARE

NEW PATIENT PAPERWORK

Full Name: _____ **Social Security Number:** _____ - _____ - _____

Date of Birth: _____ **Gender:** M F

Address: _____ **Primary Phone:** _____

_____ **Mobile Phone:** _____

Work Phone: _____

Email Address ***(required)***: _____

Marriage Status: S M D W Other

Your Employment: _____

Providers:

Primary Care Physician: _____

Referring Physician: _____

Pharmacy Name and City: _____

Past Medical History:

- o **NO PAST MEDICAL HISTORY**
- o **Anxiety**
- o **Arthritis**
- o **Asthma**
- o **Atrial Fibrillation**
- o **Bone Marrow Transplantation**
- o **GERD (heartburn)**
- o **Breast Cancer**
- o **Colon Cancer**
- o **COPD (lung disease)**
- o **Coronary Artery Disease (heart disease)**
- o **Depression**
- o **Diabetes**
- o **End Stage Renal Disease**
- o **Other** _____
- o **Hepatitis (liver disease)**
- o **Hypertension (high blood pressure)**
- o **HIV/AIDS**
- o **Hypercholesterolemia (high cholesterol)**
- o **Thyroid Disease**
- o **Leukemia**
- o **Lung Cancer**
- o **Lymphoma**
- o **Prostate Cancer**
- o **Radiation Treatment**
- o **Seizures**
- o **Stroke**
- o **Currently Pregnant or Planning Pregnancy**

Social History:

Smoking: Are you a: Non-Smoker Current Smoker Former Smoker

Alcohol: How many times in the past year have you had 5 drinks (for men) or 4 drinks (for women and all adults older than 65 years) or more in a 1 day period. _____

Do you wear sunscreen? Y N If yes, what SPF? _____

Do you tan at a tanning bed? Y N

Family History:

Do you have a family history of Melanoma? Y N If yes, which relative? _____

We will review your medications, allergies and any additional medical or surgical history in the exam room.