



EMA New PATIENT PAPERWORK

Full Name: _____

Social Security Number: _____ - _____ - _____

Date of Birth: _____

Gender: M F

Address: _____

Primary Phone: _____

Mobile Phone: _____

Work Phone: _____

Email Address (**required**): _____

Relationship Status: S M D W Other

Your Employment: _____

Providers:

Primary Care Physician: _____

Referring Physician: _____

Pharmacy Name and City: _____

Past Medical History:

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

