COMPLEXIONS
DERMATOLOGY

Patient Information

Last Name ____________ First Name ____________ Middle Initial ____________

Address ____________

City ____________ State ____________ Zip ____________

Home # (____) ____________ Cell # (____) ____________

Work # (____) ____________ Email Address ____________

SS # ____________ Date of Birth ____________

Sex M ___ F ___ Marital Status (circle one) Single Married Divorced Widowed

Race ____________ Ethnicity Hispanic or Non-Hispanic Preferred Language ____________

Patient's Employer ____________

Address ____________

City ____________ State ____________ Zip ____________

Emergency Contact: ____________ Phone Number: ____________

Relationship to Patient: ____________

Guarantor Information

Type of insurance? ____________

Last Name ____________ First Name ____________ Middle Initial ____________

Relationship to patient ____________ ***If self, do NOT fill out information in this section.***

Address ____________

City ____________ State ____________ Zip ____________

Date of Birth ____________ Guarantor's SS # ____________

Home # (____) ____________ Cell # (____) ____________

Employer ____________

Patient Medical History

Skin Disease History

- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Basal Cell Skin Cancer
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaky or Itchy Scalp
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Blistering Sunburns # ________
- ❑ Pre-cancerous Moles
- ❑ Psoriasis
- ❑ Squamous Cell Skin Cancer

Reason for Visit ____

Please check ALL that apply to your health

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ BPH
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ Hypothyroidism
- ❑ Hypertension
- ❑ Hyperthyroidism
- ❑ Inflammatory Bowel Disease
- ❑ Leukemia or Lymphoma
- ❑ Lung Cancer
- ❑ Prostate Cancer
- ❑ Previous Radiation Treatment
- ❑ Seizures
- ❑ Stroke

Surgery History

- ❑ Appendix
- ❑ Breast Cancer
  Left, Right or Both
  Mastectomy or Lumpectomy
- ❑ Breast Implants
- ❑ Colon Resection
- ❑ Gallbladder (Cholecystectomy)
- ❑ Coronary Artery Bypass Surgery
- ❑ Heart Valve Replacement
- ❑ Hysterectomy
- ❑ Joint Replacement
  Hip or Knee
  Left, Right or Both
- ❑ Kidney Transplant
- ❑ Skin Cancer Excision
- ❑ Tonsils
- ❑ Other________________________

Social History Details

- ❑ Are you pregnant?
- ❑ Are you trying to get pregnant?
- ❑ Do you have a family history of melanoma?
  If so, how are they related?________________________________
- ❑ Do you smoke? _________ pks/day
- ❑ Do you use sunscreen? SPF # ______
- ❑ Do you tan in a tanning bed?
  If so, how often? ____

Current Medications

__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________
__________________________________ __________________________________

Are you allergic to any medications?

______________________________ ______________________________

______________________________ ______________________________

Additional Medical Information

____

____

____

Who may we thank for your referral?

- ❑ Newspaper
- ❑ Internet/Google search
- ❑ Hospital Referral
- ❑ Friend/Relative
- ❑ Other

Name: ______________________________

____

Preferred Pharmacy

Pharmacy Name ______________________________

Address______________________________ City ______________________________ State______

Phone (______) ______________________________

Check All That Apply

Condition			Condition			Condition		
Immunosuppression	❑ Yes	❑ No	Joint Aches	❑ Yes	❑ No	Allergy to lidocaine	❑ Yes	❑ No
Fever or Chills	❑ Yes	❑ No	Muscle Weakness	❑ Yes	❑ No	MRSA	❑ Yes	❑ No
Night Sweats	❑ Yes	❑ No	Headaches	❑ Yes	❑ No	Allergy to topical antibiotic ointments	❑ Yes	❑ No
Unintentional Weight Loss	❑ Yes	❑ No	Seizures	❑ Yes	❑ No			
Blurry Vision	❑ Yes	❑ No	Anxiety	❑ Yes	❑ No	Artificial heart valve	❑ Yes	❑ No
Sore Throat	❑ Yes	❑ No	Depression	❑ Yes	❑ No	Artificial joints within past two years	❑ Yes	❑ No
Thyroid Problems	❑ Yes	❑ No	Shortness of Breath	❑ Yes	❑ No			
Bloody Stool	❑ Yes	❑ No	Blood thinners	❑ Yes	❑ No	Defibrillator	❑ Yes	❑ No
Bloody Urine	❑ Yes	❑ No	Pacemaker	❑ Yes	❑ No	Premedication prior to procedures	❑ Yes	❑ No
Problems with Bleeding	❑ Yes	❑ No	Rapid heart beat with epinephrine	❑ Yes	❑ No			
Rash	❑ Yes	❑ No						
Problems with Healing	❑ Yes	❑ No	Pregnancy or planning a pregnancy	❑ Yes	❑ No			
Problems with Scarring (hypertrophic or keloid)	❑ Yes	❑ No						
			Allergy to adhesive	❑ Yes	❑ No			

Thank you for using Complexions Dermatology for all of your skin care needs