ALLSKIN
DERMATOLOGY
Terri R. Dunn, M.D. Miriam Ferreira, PA-C

# MEDICAL INFORMATION

(Updated 01/01/17)

Name_____ Today's Date_____

Date of Birth _____ Age_____ Family Physician_____

How were you referred to AllSkin Dermatology?_____

EMAIL:_____

***PLEASE CHECK BOX IF YOU WOULD LIKE TO RECEIVE OUR NEWSLETTER ☐ YES ☐ NO**

Patient History (past and present) Please circle yes or no:

| | | | | | |
|---|---|---|---|---|---|
| Liver Disease | __Y__ N | Ulcers | __Y__ N | Seizures | __Y __N |
| Kidney Disease | __Y __N | Diabetes | __Y __N | Thyroid Disorders | __Y __N |
| Lung Disease | __Y __N | Asthma | __Y __N | Hypertension | __Y __N |
| Heart Disease | __Y__ N | Smoker | __Y __N | Seasonal/Food Allergies | __Y __N |
| Eye Disorders | __Y__ N | Mental Illness | __Y __N | Alcoholism | __Y__ N |
| Bleeding Disorder | __Y __N | Drug Addiction | __Y __N | Ear, Nose, or Throat Disorders | __Y __N |
| Rheumatic Fever | __Y __N | Surgeries | __Y __N | Cancer | __Y __N |
| Infectious Diseases | __Y __N | Arthritis | __Y __N | Other | __Y __N |

If yes to any of the above, please explain _____

_____

_____

Have you ever been diagnosed with a skin cancer? __Y__ N
If yes, what type? _____

Family History (blood relatives only) Please circle yes or no and specify relationship:

| | | | | | |
|---|---|---|---|---|---|
| Melanoma | __Y __N | Ulcers | __Y__ N | Blood disorders | __Y __N |
| Liver Disease | __Y __N | Hypertension | __Y __N | Arthritis | __Y__ N |
| Kidney Disease | __Y __N | Diabetes | __Y __N | Thyroid Disorders | __Y__ N |
| Lung Disease | __Y__ N | Allergies | __Y __N | Other | __Y __N |

Please list current medications, including prescriptions, over-the-counter, and herbal preparations, also list creams, ointments, etc.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Pharmacy name and phone number:_____

ALLERGIES TO MEDICATIONS? __Y __N
Please list:_____

The above information is accurate and complete to the best of my knowledge and is for use in my treatment, billing, and processing of insurance. I will not hold my physician or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Patient Signature Date Physician /M.A