Ada West
DERMATOLOGY

ADULT PATIENT INFORMATION - Page 1

Name:____
(Last Name) (First Name) (Middle Name)

Date of Birth:__________________ **Birth Sex**: ☐ Male ☐ Female **Gender Identity**:________________
(Optional)

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

DEMOGRAPHIC & CONTACT INFORMATION

Preferred Language: ☐ English ☐ Spanish ☐ Other:______________________________

Preferred Appointment Reminder: ☐ Phone ☐ Email ☐ Text ☐ Decline Reminders

Emergency Contact:__________________________**Relationship**:______________**Phone**:________________

Patient Home Phone:_________________________**Patient Mobile Phone:**______________________________
Preferred Phone: ☐ Home ☐ Mobile

Is it ok to leave a detailed message on your answering machine/voicemail if you are unavailable? ☐ Yes ☐ No

Email Address:____

Mailing Address:____
(Street or PO Box) (City) (State) (Zip Code)

Pharmacy Name:___________________________**Street**:_________________________**City**:______________

Primary Care Provider (First & Last Name):______________________________**Phone**:________________

INSURANCE INFORMATION (Required)

☐ Check here if you are **NOT INSURED** (If not insured, please skip insurance information section)

Primary Insurance:____Policy or ID #__________________________

Primary Policy Holder Name:________________________________Date of Birth:__________________________

Primary Policy Holder Relationship to Patient:____

Primary Policy Holder’s Employer:____
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Secondary Insurance:_____________________________________Policy or ID#___________________________

Secondary Policy Holder Name:______________________________Date of Birth:__________________________

Secondary Policy Holder Relationship to Patient:____

Secondary Policy Holder’s Employer:____

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ADULT PATIENT INFORMATION - Page 2

Patient Name: **DOB:**

Past Medical Conditions (Please check all that apply)

☐ None	☐ Coronary artery disease	☐ Human immunodeficiency virus infection (HIV)
☐ Anxiety disorder	☐ Depressive disorder	
☐ Arthritis	☐ Diabetes mellitus	☐ Hypercholesterolemia
☐ Asthma	☐ End-stage renal disease	☐ Hyperthyroidism (High)
☐ Atrial fibrillation	☐ Gastroesophageal reflux disease	☐ Hypothyroidism (Low)
☐ Cancer, Type:	☐ Hypertension	☐ Leukemia
☐ Cerebrovascular accident (Stroke)	☐ Hearing loss	☐ Malignant lymphoma
☐ Chronic hepatitis (A or B or C?)	☐ History of radiation therapy	☐ Other

Past Surgeries (Please check all that apply)

☐ None	☐ History of colectomy	☐ Tonsillectomy and adenoidectomy
☐ Biopsy of skin	☐ Hysterectomy	
☐ Coronary artery bypass graft	☐ Mastectomy of left breast	☐ Total knee replacement
☐ Excision of melanoma	☐ Mastectomy of right breast	☐ Total nephrectomy-kidneys
☐ H/O: tubal ligation	☐ Oophorectomy-Ovaries removal	☐ Tympanostomy (Ear tubes)
☐ Heart valve replacement	☐ Prosthetic arthroplasty of the hip	☐ Other

Skin Conditions (Please check all that apply)

☐ None	☐ Dysplastic nevus	☐ History of squamous cell carcinoma
☐ Acne	☐ Eczema	
☐ Actinic keratosis	☐ H/O Malignant melanoma	☐ Pruritus of scalp
☐ Biopsy of skin	☐ History of malignant basal cell Neoplasm of skin	☐ Psoriasis
☐ Dry Skin		☐ Sunburn of second degree
☐ Other		

Skin Protection

Do you wear sunscreen? ☐ Yes ☐ No If Yes, what SPF?_________________

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of melanoma? ☐ Yes ☐ No (If yes please check all that apply)

☐ None	☐ Daughter	☐ Niece
☐ Mother	☐ Son	☐ Grandmother
☐ Father	☐ Uncle	☐ Grandfather
☐ Sister	☐ Aunt	☐ Grandson
☐ Brother	☐ Nephew	☐ Granddaughter

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ADULT PATIENT INFORMATION - Page 3

Patient Name: **DOB:**

Medications: ☐ **None**, ☐ **List** all current medication information below, ☐ **Current** medication list attached

Name of medication/supplement	Strength (i.e. 100)	Unit (i.e. mg)	Dosage (How Many)	Frequency (How Often)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Allergies: ☐ **None** or please list all allergies below.

1.	5.
2.	6.
3.	7.
4.	8.

Occupation:____

Alerts: Do you have any of the following? (Please check yes or no)

Condition/Alert	Yes	No	Condition/Alert	Yes	No
Allergy to Latex			MRSA		
Allergy to Adhesive			Pacemaker		
Allergy to Lidocaine			Premedication Prior to Procedures		
Allergy to Topical Antibiotic Ointments			Rapid Heartbeat with Epinephrine		
Artificial Heart Valve			Pregnancy or Planning a Pregnancy		
Artificial Joints Within Past Two Years			HIV/AIDS		
Blood Thinners			Hepatitis A, B or C		
Defibrillator					