NASHVILLE SKIN COMPREHENSIVE DERMATOLOGY CENTER

PLEASE PRINT

CONTACT INFORMATION

LAST NAME_____ FIRST NAME _____ MIDDLE INITIAL _____

GENDER (circle one): MALE / FEMALE SSN _____ MARITAL STATUS _____ BIRTHDATE _____

RACE_____ ETHNIC GROUP _____ PREFERRED LANGUAGE _____
EX: AFRICAN AMERICAN EX: HISPANIC EX: ENGLISH

STREET ADDRESS CITY STATE ZIP

PRIMARY PHONE SECONDARY PHONE WORK PHONE

E-MAIL YOUR EMPLOYER PRIMARY CARE PROVIDER

PREFERRED PHARMACY PHARMACY ADDRESS PHARMACY PHONE

YOU MAY CONTACT ME AT: (check all) ____HOME ____CELL ____WORK

MAY WE LEAVE VOICEMAILS REGARDING YOUR HEALTH INFORMATION? (check one) ____YES ____NO

WERE YOU REFERRED BY ANOTHER PROVIDER? ____YES ____NO IF YES, WHO? _____

HOW DID YOU HEAR ABOUT US?_____

INSURANCE

PRIMARY INSURANCE RELATION SECONDARY INSURANCE RELATION

NAME OF POLICY HOLDER ADDRESS (IF DIFFERENT) NAME OF POLICY HOLDER ADDRESS (IF DIFFERENT)

POLICY HOLDER'S DOB POLICY HOLDER'S DOB

POLICY HOLDER'S SSN POLICY HOLDER'S SSN

PLEASE LIST CURRENT MEDICATIONS

(INCLUDING VITAMINS AND OVER-THE-COUNTER)

1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.

ARE YOU ON ANY BLOOD THINNERS? ___YES ___NO

___ASPIRIN ___COUMADIN ___PLAVIX ___XARELTO ___VITAMIN E

MEDICATION ALLERGIES (LIST ALL THAT APPLY)

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

CONTINUED ON REVERSE SIDE

PLEASE PRINT

PAST MEDICAL HISTORY

(CHECK ALL THAT APPLY)

___SKIN CANCER
(INDICATE TYPE BELOW)
___MELANOMA
___BASAL CELL CARCINOMA
___SQUAMOUS CELL CARCINOMA

___PSORIASIS
___ECZEMA
___LUPUS
___SCLERODERMA
___ATYPICAL MOLES
___DIABETES
___HEART ATTACK

___STROKE
___BLOOD CLOT
___ATRIAL FIBRILLATION
___SEIZURES
___THYROID PROBLEM
___ANEMIA
___EMPHYSEMA

___HIGH BLOOD PRESSURE
___HEPATITIS B
___HEPATITIS C
___HIV
___TUBERCULOSIS
___BLEEDING PROBLEM

HAVE YOU HAD CANCER OTHER THAN SKIN CANCER? ___YES ___NO IF YES, WHAT TYPE? _____

HAVE YOU HAD AN ORGAN TRANSPLANT? ___YES ___NO IF YES, WHAT TYPE? _____

HAVE YOU HAD A JOINT REPLACEMENT? ___YES ___NO IF YES, WHAT JOINT AND WHAT YEAR? _____

HAVE YOU HAD A HEART VALVE REPLACEMENT? ___YES ___NO
DO YOU HAVE A PACEMAKER OR DIFIBRILLATOR? ___YES ___NO

FEMALES ONLY: Are pregnant?___YES ___NO FEMALES ONLY: Are you currently breastfeeding? ___YES ___NO

FAMILY HISTORY

PLEASE INDICATE ANY CONDITIONS PRESENT IN IMMEDIATE FAMILY

MELANOMA ___YES ___NO IF YES, RELATION_____

PSORIASIS ___YES ___NO IF YES, RELATION_____

LUPUS ___YES ___NO IF YES, RELATION_____

CANCER ___YES ___NO IF YES, RELATION AND TYPE _____

OTHER ___YES ___NO IF YES, WHAT AND RELATION _____

SOCIAL HISTORY

DO YOU SMOKE? ___YES ___NO IF YES, HOW MANY YEARS? _____ DO YOU CONSUME ALCHOHOL ON A REGULAR BASIS? ___YES ___NO

REVIEW OF SYSTEMS

PLEASE INDICATE ANY SYMPTOMS YOU HAVE RECENTLY EXPERIENCED
(CHECK ALL THAT APPLY)

___FEVER
___CHILLS
___NIGHT SWEATS
___WEIGHT LOSS
___FATIGUE
___HEADACHE
___SIEZURES
___DIZZINESS
___NUMBNESS

___COUGHING
___WHEEZING
___BLOODY SPUTUM
___SHORTNESS OF BREATH
___NOSE BLEEDS
___MOUTH ULCERS
___DRY EYES
___BLURRED VISION

___CHEST PAIN
___PALPITATIONS
___ENLARGED LYMPH NODES
___NAUSEA
___VOMITING
___DIARRHEA
___ABDOMINAL PAIN
___EASY BLEEDING

___BLOOD IN URINE
___URINARY PAIN
___FREQUENT URINATION
___GENITAL SORES
___IRREGULAR MENSES
___ARTHRITIS
___MUSCLE ACHES

___MUSCLE CRAMPS
___HAIR LOSS
___EXCESS HAIR
___INCREASED SWEATING
___ANXIETY
___DEPRESSION
___SUICIDAL THOUGHTS

I, the undersigned, authorize Nashville Skin and staff to provide medical service to me and authorize the disclosure of protected health information for purpose of payment, health care operations, and treatment.

PATIENT SIGNATURE _____ DATE _____ PROVIDER SIGNATURE _____ DATE _____