Seacoast Dermatology, PLLC

NEW PATIENT INFORMATION (Please print)

Todays Date _____ Name (Last, First, MI) _____

Date of Birth ____/____/____ **Reason for Visit:** _____

Primary Care Physician _____ Referring Physician _____

Is it OK to leave a detailed message if we need to call you? Yes No

Preferred pharmacy: _____City & State :_____

Email address: _____
(For patient portal and account communications)

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Hyper/Hypo Thyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Heart Attack
NONE
Other:_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy
Breast Reduction
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
NONE
Other:_____

Skin Disease History: (please circle all that apply)

Acne		
Actinic Keratoses	Dry Skin	Poison Ivy
Asthma	Eczema	Precancerous Moles
Basal Cell Skin Cancer	Flaking or Itchy Scalp	Psoriasis
Blistering Sunburns	Hay Fever/Allergies	Squamous Cell Skin Cancer
	Melanoma	**NONE**

Other:_____

Do you wear Sunscreen? Yes No If yes, what SPF? _____
Do you tan in a tanning bed? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Influenza Vaccine - Check the one that best fits:
_____Received a flu vaccine this flu season.
_____Did not receive a flu vaccine this flu season because of medical reasons.
_____Did not receive a flu vaccine this flu season because I don't want one.
_____Did not receive a flu vaccine this flu season.

Pneumococcal Vaccine (For patients 65 and older Only) - Check the one that best fits:
_____Received a pneumococcal Vaccine (Pneumovax).
_____Did not receive a pneumococcal Vaccine.

Other Vaccines (For patients who are EXACTLY 13 years old) If you are not currently 13 years old, please skip this question. Check ALL that apply:
_____Received one dose of meningococcal vaccine on or between my 11-13th birthday.
_____Received one tetanus, diphtheria and pertussis vaccine (Tdap) on or between my 10th and 13th birthdays.
_____Received at least three HPV vaccines on or between my 9th and 13th birthdays.

Medications: (Please enter all current medications)
_____
_____

Drug allergies & type of reaction:
_____
_____

Other allergens causing a severe reaction:

_____

_____

Social History:

Cigarette Smoking: (Circle all that apply)

Currently Smoke
Never smoked
Former Smoker

Alcohol Use: Screening

How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? _____

Family History Illnesses (first-degree relatives only)

_____

_____

Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Feeling ill, fever or chills?		
Worrisome skin lesion?		
Immunosuppression issues?		
Problems with bleeding?		
Rash?		
Accutane (Isotretinoin) use?		

Other Symptoms: _____

Alerts: Please circle all that apply.		
MRSA	Allergy to Adhesive	Allergy to lidocaine
Allergy to topical antibiotics	Artificial heart valve	Artifical joint replacement in last 2 yrs
Blood thinners	Defibrillator	Pacemaker
Require antibiotics prior to surgery	Rapid heart beat with epinephrine	Are you pregnant or currently trying to get pregnant?
West Africa: Travel or contact	HIV positive	Hepatitis positive

Advance Directives: Advance directives are designed to respect your autonomy and determine your wishes about future life sustaining medical treatment if you are unable to indicate your wishes. Key interventions and treatment decisions are: resuscitation procedures such as Cardiopulmonary Resuscitation (CPR), and mechanical respiration (breathing tube). ***If you answered yes, you may provide our office with a copy.***

Which statement(s) **best reflect** your wishes on advanced care recommendations?
_____I want full cardiopulmonary resuscitation efforts to be made (Full Code).
_____I do not wish to have a breathing tube, even if it is necessary to save my life (Do Not Intubate).
_____If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life (Do Not Resuscitate).
_____I have a living will.
_____I have a health care proxy whose name is _____ and contact information is _____.

If you would like to DESIGNATE A PERSONAL REPRESENTATIVE to assist with your healthcare decisions at Seacoast Dermatology, PLLC, please ask for a form at check-in.

Are you interested in discussing any of the following with the doctor?

_____BOTOX Cosmetic _____Dermal fillers

_____Lasers Treatments (for wrinkles, red spots, brown spots, scars, skin tightening, blue or red veins, unwanted hair)