CHI
DERMATOLOGY

Welcome to Chi Dermatology!

Please complete this form and bring to your appointment with **Insurance card** and **Driver's License or Identification Card** as well as your **medication list** if applicable. Please notify us any time you have changes to your medical record including address, phone, or insurance.

If you have an HMO insurance plan, you are responsible for obtaining the proper authorization/referral from your Primary Care Physician. We will reschedule your appointment if we have not received paperwork prior to your appointment.

<table>
<tr><td colspan="2">Name (First, Middle, Last)</td><td>Social Security #</td><td>□ Male
□ Female</td><td>Date of Birth</td></tr>
<tr><td colspan="3">Street Address Apt. Number</td><td colspan="2">Seasonal Address Street Address (if applicable)</td></tr>
<tr><td colspan="3">City/State/Zip</td><td colspan="2">City/State/Zip</td></tr>
<tr><td colspan="3">Email Address</td><td colspan="2">*Emergency Contact : _____
*Phone # _____</td></tr>
<tr><td>Home Phone #</td><td>Cell Phone #</td><td colspan="3"></td></tr>
<tr><td colspan="3">How did you hear about us?
□ Website/Internet □ Family Friend □ Facebook
□ Magazine □ Signage □ PCP Referral □</td><td colspan="2">Primary Language
□ English □ Spanish □ Other</td></tr>
<tr><td colspan="5">*THIS SECTION MUST BE COMPLETED
Did a Physician refer you to our practice? □ YES □ NO
If yes, please supply the name of the Physician Name: _____ Phone: _____
Primary Care Physician: Name: _____ Phone: _____
Preferred Pharmacy : Name _____ Phone: _____
Cross Street if unable to supply phone: _____</td></tr>
</table>

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Health History Form

Past Medical Conditions (please circle all that apply)

NONE
Anxiety disorder
Arthritis
Asthma
Atrial fibrillation
Benign prostatic hyperplasia
Cerebrovascular accident
Chronis obstructive lung disease
Coronary arteriosclerosis
Depressive disorder
Diabetes mellitus
Disease caused by COVID 19
Elevated blood pressure
End stage renal disease
Epilepsy
Gastroesophageal reflux disease
Hypertension
Hearing loss
Human immunodeficiency virus infection
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Inflammatory disease of the liver
Leukemia
Malignant lymphoma
Malignant tumor of lung
Malignant tumor of breast
Malignant tumor of colon
Malignant tumor of prostate
Radiation therapy treatment management
Transplant of bone marrow
Other: _____

Past Surgeries (please circle all that apply)

NONE
Abdominoperineal resection
Bilateral replacement of knee
Biopsy of breast
Biopsy of prostate
Coronary artery bypass graft
Entire transplanted kidney
Excision of basal cell carcinoma
Excision of melanoma
Excision of squamous cell carcinoma
Colostomy
Tubal ligation
Appendectomy
Total cystectomy
Transurethral prostatectomy
Hysterectomy
Kidney biopsy
Low anterior resection of rectum
Lumpectomy of breast L R
Mastectomy of breast L R
Mechanical right valve replacement
Oophorectomy
Pancreatectomy
Percutaneous extraction of kidney stone
Portosystemic shunt operation
Prostatectomy

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Bilateral mastectomy	Prosthetic arthroplasty of bilateral hips
Cholecystectomy	Splenectomy
Colectomy	Surgical biopsy of skin
Liver excision	Total knee replacement L R Date:_____
Percutaneous transluminal coronary angio	Total hip replacement L R Date:_____
Tissue graft heart valve replacement	Heart Transplant
Other: _____	Liver Transplant

Skin Disease History (please circle all that apply)

NONE	
Acne	Malignant melanoma Date/Location:_____
Actinic keratosis	Dry scalp
Dry Skin	Psoriasis
Asthma	Squamous cell carcinoma
Basal cell carcinoma	Sunburn (second degree)
Contact dermatitis due to poison ivy	History of Effudex use
Dysplastic nevus of the skin	History of cold sores
Eczema	History of hay fever/allergies
History of asthma	Other: _____

Do you wear Sunscreen YES NO SPF? _____
Do you tan in a tanning salon YES NO
Do you have a family history of melanoma YES NO
If yes, please select family members with history of melanoma:
□ Mother □ Father □ Sister □ Brother □ Other_____
Have you completed a PDT (blue light therapy treatment) in the past? YES NO Date: _____

Please list the medications you **currently** take:

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Medication	Dosage	Route (Oral, injection or topical)

MEDICATION ALLERGIES (please list): _____
_____

NO KNOWN ALLERGIES NKA □

Review of Systems: Please check YES or NO

SYMPTOM	YES	NO
Fever or Chills		
Unintentional Weight Loss		
Night Sweats		
Enlarged Lymph Nodes		
Problems with Bleeding		
Rash		
New or Changing Mole		

Alerts: Please check all that currently apply:

ALERT	YES	NO
Pacemaker		
Defibrillator		
Pre-Medications prior to procedures		
Artificial Heart Valve		
Allergy to Lidocaine		

Rapid Heartbeat with Epinephrine		
Allergy to Adhesive/Tape		
Allergy to Topical Antibiotic Ointments		
Blood Thinners		
MRSA Staph Infection		
Pregnancy or planning one		
Breastfeeding		
Hospice		

Please list any other pertinent health information:

_____

_____