Basuk Dermatology

Today's date:

Patient Information

Patient's Last Name	First	Middle	❑Mr. ❑Mrs. ❑Ms. ❑Dr.	Marital Status ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed
SSN:	Date of Birth	Sex ❑M ❑F	Preferred Language ❑English ❑Spanish Other_____	
Fill in all and **Check** ✓ preferred contact	❑Home phone #	❑Cell phone #	❑Email address	
Street Address:				
City	State	Zip		
Occupation:	Employer:	Work phone:		

Race	Ethnicity
❑White ❑Asian ❑Black or African-American ❑Prefer not to answer / Other race Other_____	❑Hispanic/Latino ❑Not Hispanic/Latino ❑Prefer not to answer / Unknown

Insurance Information

(Please give your insurance card to the receptionist)

Are you covered by insurance?

❑Yes ❑No

Primary Insurance Co.	Policy #	Group ID:
Primary Ins Subscriber's Name	Patient's relationship to Subscriber: ❑Self ❑Spouse ❑Child ❑Other	
Secondary Insurance Co.	Secondary Policy #	Secondary Group ID:
Secondary Ins Subscriber's Name	Patient's relationship to Secondary Subscriber: ❑Self ❑Spouse ❑Child ❑Other	
Preferred Pharmacy Name & Address		Pharmacy phone #

Referred by: (Doctor's name)		Primary Care Physician (if same, write 'Same')	
Address:	Phone:	Address:	Phone:
City, State, Zip:		City, State, Zip:	

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Medical History

Check all that apply:

❑Anxiety	❑COPD (Emphysema)	❑Hypertension	❑Pacemaker
❑Arthritis	❑Coronary Artery Disease	❑HIV / AIDS	❑Prostate Cancer
❑Asthma	❑Depression	❑Hypercholesterolemia	❑Radiation Treatment
❑Atrial fibrillation	❑Diabetes	❑Hyperthyroidism	❑Seizures
❑BPH (Prostate Enlargement)	❑End Stage Renal Disease	❑Hypothyroidism	❑Stroke
❑Bone Marrow Transplantation	❑GERD (Reflux)	❑Leukemia	❑Valve Replacement
❑Breast Cancer	❑Hearing Loss	❑Lung Cancer	❑None
❑Colon Cancer	❑Hepatitis (Type A, B, C)	❑Lymphoma	

Other:

Skin Disease History

❑Acne	❑Dry Skin	❑Poison Ivy
❑Actinic Keratoses	❑Eczema	❑Precancerous Moles
❑Asthma	❑Flaking or Itchy Scalp	❑Psoriasis
❑Basal Cell Skin Cancer	❑Hay Fever / Allergies	❑Squamous Cell Skin Cancer
❑Blistering Sunburns	❑Melanoma	❑None
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? ❑No ❑Yes⇨ ❑Mother ❑Father ❑Sister ❑Brother ❑Son ❑Daughter
Do you have a family history of Diabetes? ❑No ❑Yes⇨ ❑Mother ❑Father ❑Sister ❑Brother ❑Son ❑Daughter

Review of Systems

❑History of Melanoma	❑Depression	❑Defibrillator
❑History of NonMelanoma Skin Cancer	❑Headaches	❑Problems with bleeding
❑History of Atypical Nevi	❑Fatigue	❑Problems with scarring (hypertrophic or keloid)
❑New or Changing Moles	❑Fever or chills	❑Artificial joints within past two years
❑Other Skin Conditions or Rash	❑Chest pain	❑Artificial heart valve
❑Pregnancy or planning a pregnancy	❑Joint aches	❑Premedication prior to procedures
❑Unintentional weight loss	❑Asthma / Shortness of Breath	❑Allergy to lidocaine
❑Hay fever	❑Thyroid problems	❑Allergy to adhesive
❑Nausea/Vomiting/Diarrhea	❑Blood thinners	❑Allergy to topical antibiotic ointments
❑Abdominal pain	❑Pacemaker	❑Problems with healing

❑None of the above

Medications

Please list all your current medications (write NONE if none)

If you are **allergic** to any medications, please list them or write NONE

Social History

Smoking: ❑Never smoked ❑Former smoker ❑Currently smoke, not daily ❑Daily smoker