Mohs & Dermatology Associates_New Patient Evaluation Form

Today's Date:_____

Physician you are scheduled to see (Please circle): Dr Nguyen Dr Farnsworth

How did you hear about us? (please circle all that applies)

Another patient My doctor Insurance Referred Website/Internet Magazine flyer

Other:_____

Patient Name: Last_____ First _____Birth date:_____

How do you prefer to be addressed? _____

Gender (please circle): Male / Female Social Security Number: _____ - _____ - _____

Address (Street, City, State, Zip Code): _____

_____

Email (We do not share your email with anyone. It is used for patient communication only.)

_____

Phone Number:_____ Alternate Phone Number:_____

Emergency Contact (Name and Phone): _____

Insurance Information

Primary Insurance:_____ Policy number:_____

Secondary Insurance:_____ Policy number:_____

Name Policy Holder:_____ Birthdate Policy Holder:_____

_____

Assignment of Insurance Benefits and Authorization for Release of Information

I request that payment of authorized Medicare, Medigap or other insurance benefits be made on my behalf to Northwest Diagnostic Clinic, PA for any services furnished to me by one of the providers associated with that practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) , its agents, and/or my Medigap or other insurer any information needed to determine these benefits or the benefits payable for related services. This authorization shall continue until such time as I revoke it in writing.

Signature:_____Date: _____

Date:_____Patient name_____Birthdate_____

Referring Doctor:_____

Address (Street, City, State, Zip Code): _____

_____

Phone:_____ Fax:_____

Primary Care Doctor: _____

Address (Street, City, State, Zip Code): _____

_____

Phone:_____ Fax: _____

How can we help you? *Please check all that apply*

___ Changing Lesion ___ Worrisome spot ___ Skin Cancer ___ Rash

___ Vein evaluation ___ Scar Revision ___ Cosmetic Consult ___ 2nd Opinion

Other reasons for visit_____

_____

_____

Social History

Occupation: _____Retired_____

Marital Status ____Married ____Single ____Divorced ____Widowed

Spouse/Partner's name _____

How many children do you have? _____

Do you live by yourself? ____Yes ____No

Do you smoke or chew? ____Yes ____No If Yes, how much?_____

_____

Do you drink alcohol? ____Yes ____No If Yes, how much?_____

_____

Do you faint or feel light headed with blood draws or with surgery? ____Yes ____No

ALLERGIES	What reaction do you have to this drug?
1	
2	
3	
4	
Do you have any other reactions or precautions we should know?	

Vitamins /Herbals/ Over the Counter Medications: _____

_____

_____

Please list your medications	**Directions/Dosage (if known)**
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	

Personal Skin Cancer History:	____None		**If yes, where?**
Melanoma	____Yes	____No	_____
Basal Cell Cancer	____Yes	____No	_____
Squamous Cell Cancer	____Yes	____No	_____
Actinic Keratosis (Precancer)	____Yes	____No	_____
Have you had skin cancer surgery?	____Yes	____No	_____

Other:_____

Family Skin Cancer History:	____None		**If Yes, who?**
Melanoma	____Yes	____No	_____
Basal Cell Cancer	____Yes	____No	_____
Squamous Cell Cancer	____Yes	____No	_____

How sensitive are you to the sun? *Please Check only one answer*

____I Always burn, never tan
____II Always burn, but sometimes tan
____III Sometimes burn, but always tan
____IV Never burn, always tan

Sun Protection Practices:

Do you wear sunscreens with UVA and UVB protection (broad spectrum) and SPF 30 or greater?	____Yes	____No
Do you wear a hat with 4 inch brim all around?	____Yes	____No
Do you wear long sleeve clothing?	____Yes	____No
Do you avoid sun exposure during peak sun hours (between 10 AM and 4 PM)?	____Yes	____No

Please list any rejuvenation or cosmetic products you are using: _____

_____

Please check all that apply

____Previous cosmetic surgery
____**Pacemaker/Defibrillator**
____Brain stimulator
____Hip replacement- if yes when?
____Need antibiotics before dental surgery?
____Heart valve surgery
____Heart valve infection (endocarditis)
____Heart bypass surgery
____Heart rhythm problems
____Heart failure
____High blood pressure
____Blood thinners
____Circulation problems (Arterial or Veins?)
____Blood clots in deep veins
____Pulmonary embolus (clot to lungs)
____Asthma
____Emphysema, COPD
____Tuberculosis
____Immune system problems
____HIV/AIDS
____Organ transplant patient (circle all that apply): kidney, heart, lung, bone marrow, liver, pancreas

____Are you pregnant or may be pregnant?
____Diabetes
____Dialysis
____Kidney problems
____Liver disease/Cirrhosis
____Hepatitis A or B or C (circle all that apply)
____History of blood transfusions
____Bleeding problems (problems clotting)
____X-ray treatment for acne
____Radiation treatment for anything
____Anxiety or nervousness
____Psychiatric conditions
____Problems with local anesthesia
____Problems with general anesthesia
____Abnormal scarring or keloids
____Seizures
____Strokes
____Neck injuries or surgery
____Back injuries or surgery
____Raynaud's
____Autoimmune disease (circle all that apply): Lupus, Scleroderma, CREST, Sjogrens, Dermatomyositis, Rheumatoid arthritis

____History of any cancer, other than skin cancer (circle all that apply): Breast, lung, colon, thyroid, kidney, prostate, bone , leukemia, lymphoma, sarcoma, brain, pancreas, ovarian.

Do you have any other medical issues not listed above?

_____

_____

_____

_____

_____

Please check all that apply (within past 3 months)

____unplanned weight loss, weight gain
____fevers, chills
____night sweats
____nausea and vomitting
____appetite or diet changes
____easily faints
____easily falls or balance problems
____unusual headaches
____sudden vision changes
____unusual change in coordination
____recent seizures (within past 3 months)
____black or bloody stools
____recent stomach pains (within 3 months)
____blood in urine
____problems controlling bladder
____swelling in groin, armpits, or neck
____bleeding in joints when injured
____difficulty lying flat
____neck pain
____chest pain or angina
____shortness of breath
____cough (bloody or greenish sputum)

Do you wish to share anything else that may help us care for you?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for your time and for helping us take care of you.