DERMATOLOGY PARTNERS of the north shore, L.L.C.

Medical History Form

Patient Name: _____ **Date:** _____

PATIENT DEMOGRAPHICS

Legal Name: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Home Phone: ( ) _____ **Work Phone:** ( ) _____ **Cell Phone:** ( ) _____
OK to leave message: ☐ Yes ☐ No **OK to leave message:** ☐ Yes ☐ No **OK to leave message:** ☐ Yes ☐ No

Date of Birth: ____/____/____ **S.S. #:** ____/____/____ **Email Address:** _____

Marital Status (Please check one): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Gender: ☐ Male ☐ Female **Preferred Language:** _____

Transgender: ☐ FTM ☐ MTF **Biological Gender:** ☐ Male ☐ Female

Ethnic Group (Please check one):
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (Please check one):
☐ White
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Other Race

Employed By: _____ **Occupation:** _____

Have we ever treated any other member of your family? ☐ Yes ☐ No **Name(s):** _____

REFERRAL SOURCE

Referred By: ☐ Physician ☐ Family ☐ Friend **Name(s):** _____

RESPONSIBLE PARTY (Who is responsible for the account if different than above?)

Name: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Home Phone: ( ) _____ **Work Phone:** ( ) _____ **Cell Phone:** ( ) _____

Date of Birth: ____/____/____ **S.S. #:** ____/____/____ **Gender:** ☐ Male ☐ Female **Relation:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Co Name: _____
Name of Insured: _____
Address of Insured (if different): _____
_____
Date of Birth of Insured: _____
Employer Name: _____
Relationship of patient to Insured: _____

SECONDARY INSURANCE

Insurance Co Name: _____
Name of Insured: _____
Address of Insured (if different): _____
_____
Date of Birth of Insured: _____
Employer Name: _____
Relationship of patient to Insured: _____

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PHARMACY YOU USE

Name of Pharmacy: _____

Address: _____

Phone Number: _____

PAST MEDICAL HISTORY (Please check all that apply)

- ☐ **None**
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplantation
- ☐ BPH (Enlarged Prostate)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Chronic Lung Disease)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

☐ Other: _____

PAST SURGICAL HISTORY (Please check all that apply)

- ☐ **None**
- ☐ Appendix Removed (Appendectomy)
- ☐ Bladder Removed (Cystectomy)
- ☐ Breast Biopsy
- ☐ Lumpectomy ☐ Right ☐ Left
- ☐ Mastectomy ☐ Right ☐ Left
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon Removed (Colostomy)
- ☐ Gallbladder Removed (Cholecystectomy)
- ☐ Biological Valve Replacement
- ☐ Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Mechanical Valve Replacement
- ☐ PTCA (Angioplasty)
- ☐ Hip Replacement ☐ Right ☐ Left
- ☐ Knee Replacement ☐ Right ☐ Left
- ☐ Kidney Biopsy
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries Removed: Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas Removed (Pancreatectomy)
- ☐ Prostate Removed: Prostate Biopsy
- ☐ Prostate Cancer
- ☐ TURP (Prostate Surgery)
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Basal Cell Carcinoma
- ☐ Melanoma
- ☐ Skin Biopsy
- ☐ Squamous Cell Carcinoma
- ☐ Spleen Removed (Splenectomy)
- ☐ Testicles Removed (Orchiectomy)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer

☐ Other: _____

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SKIN DISEASE HISTORY (Please check all that apply)

☐ **None**

☐ Acne
☐ Actinic Keratoses
☐ Asthma
☐ Basal Cell Skin Cancer
☐ Blistering Sunburns
☐ Dry Skin
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Hay Fever / Allergies
☐ Melanoma
☐ Poison Ivy
☐ Precancerous Moles
☐ Psoriasis
☐ Squamous Cell Skin Cancer

☐ Other: _____

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? ☐ Yes ☐ No

If yes, which relative(s)? _____

Any other family history: _____

MEDICATIONS (Please enter all current medications, dosage and frequency)

May we view your online prescription history? ☐ YES ☐ NO

Medication / Dosage / Frequency	Medication / Dosage / Frequency

☐ **None**

400 Skokie Blvd
Suite 475
Northbrook, IL 60062

P: 847-272-4433 F: 847-272-4434

MEDICATION ALLERGIES (Please enter all medication allergies)

Other Allergy: _____

☐ **NO KNOWN DRUG ALLERGY**

SOCIAL HISTORY (Please check all that apply)

Cigarette Smoking:

- ☐ Current every day smoker
- ☐ Current some day smoker (tobacco)
- ☐ Current some day smoker (cigarette)
- ☐ Quit: Former Smoker
- ☐ Never Smoked
- ☐ Smoker, current status unknown
- ☐ Cigar Smoker
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker

Alcohol Use:

- ☐ None
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

FAMILY MEDICAL HISTORY (Please be specific; ONLY MAJOR MEDICAL HISTORY)

- ☐ Mother _____
- ☐ Father _____
- ☐ Sister _____
- ☐ Brother _____
- ☐ Daughter _____
- ☐ Son _____

☐ **None**