

**PATIENT REGISTRATION FORM**

Please fill out the following form *completely*.

**PATIENT – Reason for Visit?** \_\_\_\_\_

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **MI:** \_\_\_\_

**DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Referring Provider:** \_\_\_\_\_ **Pharmacy (Name/City):** \_\_\_\_\_

**Please circle one of the following:** Married Single Divorced Widowed Separated

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_

**Work Phone:** (\_\_\_\_) \_\_\_\_\_ **Email:** \_\_\_\_\_

**Home Street Address:** \_\_\_\_\_

**Home City, State, Zip:** \_\_\_\_\_

**Employer or School:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Relationship to Above:** \_\_\_\_\_ **OK to leave medical info with:** \_\_\_\_\_

**RESPONSIBLE PARTY – If same as above, please check**

**Relationship to Patient:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_ **First:** \_\_\_\_\_ **MI:** \_\_\_\_

**Sex:** M or F **DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_

**Work Phone:** (\_\_\_\_) \_\_\_\_\_ **Email:** \_\_\_\_\_

**Home Street Address:** \_\_\_\_\_

**Home City, State, Zip:** \_\_\_\_\_

**PLEASE FILL IN THE CIRCLES COMPLETELY ON THE BUBBLE SHEET**

Please fill out the following form *completely*.CORRECT: INCORRECT: **History of Present Illness**

- Itching:  Yes  No
- Duration:  Up to a month  1-6 months  6+ months
- Tender skin lesion(s):  Yes  No
- Have any lesions been bleeding:  Yes  No
- New or changing lesion(s):  Yes  No

**Past Medical History**

Personal history of the following (select all that apply):

- Eczema  Hayfever  Asthma
- Diabetes:  Yes  No
- Atypical nevi:  Yes  No
- Personal history of melanoma:  Yes  No
- History of skin cancer:  Yes  No
- Artificial Valves/Joints:  Yes  No
- Pacemaker/Defibrillator:  Yes  No
- AIDS/HIV:  Yes  No
- Pregnant:  Yes  No
- Bleeding Disorder:  Yes  No

**Family History**First degree relative with melanoma:  Yes  No

First degree relative with the following (select all that apply):

- Eczema  Hayfever  Asthma

**Social History**

How often did you have a drink containing alcohol in the past year:

- never (0 points)  monthly or less (1 point)
- 2 to 4 times a month (2 points)  2 to 3 times a week (3 points)
- 4 or more times a week (4 points)  6 or more times a week (4 points)

Are you a:  current smoker  former smoker  never smokerExercise:  Yes  NoSunscreen use:  Yes  NoRegularly uses sunscreen:  Yes  NoTanning bed use:  Yes  No**Review of Symptoms**Fever:  Yes  NoSore throat:  Yes  NoJoint pain:  Yes  No