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: _____

400 Skokie Blvd
Suite 475
Northbrook, IL 60062

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

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Medical History Form

Patient Name: _____ **Date:** _____

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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Patient Name: _____ **Date:** _____

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**

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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**