Additional Patient Information for our Records Date:_______________

Patient DOB ____/____ /____ ☐Male ☐Female

Patient Name____
First Middle Last

E-Mail Address____

Primary on Insurance____ DOB ____/____ /____
First Middle Last

Home Phone ______-_______-_________ Cell Phone _______-_______-________ Work Phone ______-_______-_________

Preferred Language:____________________ Ethnic Group: Hispanic Non-Hispanic Refuse to Answer

Race: American Indian/Alaskan Native Asian Black or African American Middle Eastern
Hawaiian or Pacific Islander White Unknown

How did you hear about us? (please circle one)

°Billboard	°Social Media: Facebook/Instagram	
°Friend	°Long Term Patient	
°Hairdresser/Barber	°Pharmacist	
°Health Fair	°Physician Referral	
°Insurance	°Radio	
°Internet Search	°Relative	°Other_______________________

Family Doctor ____

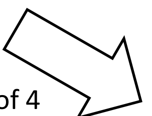
Preferred Pharmacy Name:_______________________________City____________________Street____________________

I have previously seen the following providers at this office:

☐ Dr. Anderson ☐ Dr. Bekas ☐ Dr. Peacock ☐ Michelle Hicks, NP

Like and Follow us on Facebook and Instagram

Lifetime Skin Care Centers lifetime_skin_care_centers



Patient Name_____________________________________ **Date of Birth** _______/________/_________

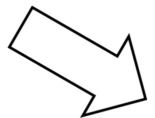
Please do not leave blank questions- **If something does not apply please circle NONE**

Past Medical History (Please circle all that apply) **NONE**

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Stroke (cerebrovascular accident)
COPD (chronic obstructive lung disease)
Coronary Artery Disease (coronary arteriosclerosis)
Depression
Diabetes
Elevated blood pressure
End-Stage Renal disease
Epilepsy
GERD (gastroesophageal reflux disease)
Hearing Loss
HIV/AIDS
Hypercholesterolemia (high cholesterol)
Hyperthyroidism
Hypothyroidism
Inflammatory disease of liver (Hepatitis)
Leukemia
MRSA
Lymphoma
Breast Cancer
Colon Cancer
Prostate Cancer
Radiation Treatment
Bone marrow transplant

Past Surgical History (Please circle all that apply) **NONE**

Appendectomy (appendix removed)
Breast Biopsy
Removal of Bladder
Removal of Gallbladder (cholecystectomy)
Coronary Artery Bypass (CABG)
Diverticulitis
Kidney Transplant
Basal Cell Treatment
Melanoma Treatment
Squamous Cell Treatment
Colon Resection (colectomy)
Removal of Kidney (nephrectomy)
Hysterectomy
IBS (irritable bowel syndrome)
Kidney Stones
Liver Transplant
Lumpectomy of Left Breast
Lumpectomy of Right Breast
Prostate Cancer
Mastectomy of Left Breast
Mastectomy of Right Breast
Heart Valve Replacement
Removal of Testicles (orchiectomy)
Removal of Pancreas (pancreatectomy)
Removal of Prostate (prostatectomy)
Removal of Spleen (splenectomy)
Biopsy of Skin
Replacement of Left Hip
Replacement of Left Knee
Replacement of Right Hip
Replacement of Right Knee
Heart Transplant
Tubal Ligation



Other Surgeries:____
____
____
____

Skin Disease History: (Please Circle all that apply) **NONE**

Acne	Malignant Melanoma
Actinic Keratoses	Psoriasis
Asthma	Seasonal Allergies
Basal Cell Skin Cancer	Squamous Cell Carcinoma
Poison Ivy	Sunburn
Atypical Moles	
Eczema	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)? ____

Medications: (Please list all current medications or attach a copy)
____
____
____
____
____

Allergies & Reactions: (Please enter all **MEDICINE** allergies and the reaction you get)
____
____
____

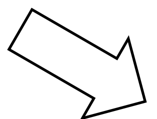
Cigarette Smoking: Never Smoked Former Smoker Currently Smokes

Alcohol Use: None Less than 1 drink per day 1-2 drinks per day 3 or more drinks per day

Occupation/Hobbies:

Patient Employer____________________________________Occupation____________________________________

Hobbies____



Review of Systems:

Are you CURRENTLY experiencing any of the following:

Problems with bleeding	Problems with healing	Problems with scarring	Immunosuppression

NONE

Alerts:

Do any of the following apply to you?

Medication allergy

Allergy to adhesive

Allergy to lidocaine

Allergy to topical antibiotics

Artificial heart valve

Artificial joints in past two years

Blood thinners

Defibrillator

MRSA

Pacemaker

Premedication prior to procedures

Rapid heartbeat with epinephrine

Pregnancy or planning pregnancy

HIV positive or AIDS

Hepatitis

Insulin Pump

Cochlear Implant

Nerve Stimulator

NONE