

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 Phone Number: 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)

<input type="radio"/> Billboard	<input type="radio"/> Social Media: Facebook/Instagram
<input type="radio"/> Friend	<input type="radio"/> Long Term Patient
<input type="radio"/> Hairdresser/Barber	<input type="radio"/> Pharmacist
<input type="radio"/> Health Fair	<input type="radio"/> Physician Referral
<input type="radio"/> Insurance	<input type="radio"/> Radio
<input type="radio"/> Internet Search	<input type="radio"/> Relative <input type="radio"/> Other _____

Family Doctor _____

Preferred Pharmacy Name: _____ City _____ Street _____

I have previously seen the following providers at this office:

Dr. Anderson Andrew Ellenwood, NP Dr. Peacock Michelle Hicks, DCNP

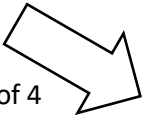
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Lifetime Skin Care Centers

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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

Blood thinners

Pregnancy or planning pregnancy

Allergy to adhesive

Defibrillator

HIV positive or AIDS

Allergy to lidocaine

MRSA

Hepatitis

Allergy to topical antibiotics

Pacemaker

Insulin Pump

Artificial heart valve

Premedication prior to procedures

Cochlear Implant

Artificial joints in past two years

Rapid heartbeat with epinephrine

Nerve Stimulator

NONE