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)

°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 ☐ Andrew Ellenwood, NP ☐ Dr. Peacock ☐ Michelle Hicks, DCNP

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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