Seaside
DERMATOLOGY

Welcome to Seaside Dermatology!

Please complete this form and bring to your appointment with your **insurance card** and **driver's license** as well as your **medication list** if applicable. Please notify us any time you have changes to your medical record including address, phone, or insurance.

If you have an HMO insurance plan, you are responsible for obtaining the proper authorization/referral from your Primary Care Physician. We will reschedule your appointment if we have not received paperwork prior to your appointment.

Name (First, Middle, Last)	**Gender** ☐ **Male** ☐ **Female**	**Date of Birth**
Mailing Address		
Seasonal Address		
Email Address		**Primary Language** ☐ **English** ☐ **Spanish** ☐ **Other: _____**
Home Phone	**Cell Phone**	**How did you hear about us?**
Emergency Contact	**Emergency Contact Phone #**	**Preferred Pharmacy**

****THIS SECTION MUST BE COMPLETED**** Did a physician refer you to our practice? ☐ Yes ☐ No	**Referring Physician Name: _____** **Primary Care Physician: _____**

Seaside Dermatology
350 S Indiana Avenue, Englewood, FL 34223
Ph: (941)474-8811 | F: (941)473-0058
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Health History Form

Past Medical Conditions (please circle all that apply)

NONE
Anxiety disorder
Arthritis
Asthma
Atrial fibrillation
Benign prostatic hyperplasia
Cerebrovascular accident
Chronic obstructive lung disease
Coronary arteriosclerosis
Depressive disorder
Diabetes mellitus
Disease caused by COVID 19
Elevated blood pressure
End stage renal disease
Epilepsy
Gastroesophageal reflux disease
Hypertension
Hearing loss
Human immunodeficiency virus infection
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Inflammatory disease of the liver
Leukemia
Malignant lymphoma
Malignant tumor of lung
Malignant tumor of breast
Malignant tumor of colon
Malignant tumor of prostate
Radiation therapy treatment management
Transplant of bone marrow
Other: _____

Past Surgeries

NONE
Abdominoperineal resection
Bilateral replacement of knee
Biopsy of breast
Biopsy of prostate
Coronary artery bypass graft
Entire transplanted kidney
Excision of basal cell carcinoma
Excision of melanoma
Excision of squamous cell carcinoma
H/O colostomy
H/O tubal ligation
H/O appendectomy
H/O bilateral mastectomy
H/O cholecystectomy
H/O colectomy
H/O liver excision
H/O percutaneous transluminal coronary angio
H/O tissue graft heart valve replacement
H/O total cystectomy
H/O transurethral prostatectomy
Hysterectomy
Kidney biopsy
Low anterior resection of rectum
Lumpectomy of breast L R
Mastectomy of breast L R
Mechanical right valve replacement
Oophorectomy
Pancreatectomy
Percutaneous extraction of kidney stone
Portosystemic shunt operation
Prostatectomy
Prosthetic arthroplasty of bilateral hips
Splenectomy
Liver Transplant
Total knee replacement L R
Total hip replacement L R
Heart Transplant

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Skin Disease History (please circle all that apply)

NONE
Acne
Actinic keratosis
Asteatosis cutis
Asthma
Basal cell carcinoma
Contact dermatitis due to poison ivy
Dysplastic nevus of the skin
Eczema
H/O asthma
H/O hay fever/ allergies
Malignant melanoma (date/location: _____)
Pruritus of scalp
Psoriasis
Squamous cell carcinoma
Sunburn (second degree)
Other: _____

Do you wear sunscreen?

- ☐ Yes
- ☐ No

SPF? _____

Do you tan in a tanning salon?

- ☐ Yes
- ☐ No

Do you have a family history of melanoma?

- ☐ Yes
- ☐ No

Family Member: _____

Please list the medications you **currently** take:

Medication	Dosage	Route (oral, injection, topical)

Medication Allergies (please list): _____

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Review of Systems (please check YES or NO):

Symptom	Yes	No
Fever or chills		
Unintentional weight loss		
Night sweats		
Enlarged lymph nodes		
Problems with bleeding		
Rash		
New or changing mole(s)		

Alerts (please check all that apply):

Alert	Yes	No
Pacemaker		
Defibrillator		
Pre-medications prior to procedures		
Artificial heart valve		
Allergy to lidocaine		
Rapid heartbeat with epinephrine		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood thinners		
MRSA staph infection		
Pregnancy or planning one		
Breastfeeding		
Hospice		

Please list any other pertinent health information:

_____

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