BOLD CITY DERMATOLOGY

Office Use Only
Follow up: _____
Clinical Photos Taken: _____

Please complete all 4 pages (front and back). We are happy to answer any questions at (904)544.5800!

PERSONAL INFORMATION:

Date: _____

Name: _____ Marital Status: _____ SSN: _____

Date of Birth: _____ /_____ /_____ Gender: Male Female

Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip: _____

Preferred Telephone #: _____ Type: Home Cell Work Other_____

Alternate Telephone #: _____ Type: Home Cell Work Other_____

Is it OK to leave a detailed message: YES NO If yes, which phone: Preferred / Alternate / Other

Email Address: _____

Preferred Contact Method (circle one): Phone Email Portal Letter Fax

Language (Please circle all that apply): English Spanish Other(s): _____ Decline

Race (Please circle):

American Indian or Native Alaskan
Asian
Black/African American
Middle-Eastern
Native Hawaiian/Pacific Islander
White
Other _____
Decline

Ethnicity (Please circle): Hispanic/Latino Not Hispanic/Latino Decline

Employment:

Employer: _____ Occupation: _____

Industry: _____ Retired: YES NO

Emergency Contact and Authorization to share Medical Information:

Name: _____ Relationship: _____ Phone #: _____

You have my permission to share medical results/information with the above person: YES NO

Any other authorized person- Name:_____ Relationship:_____ Phone: _____

Primary & Referring Doctors:

Primary Care Doctor: _____ Referring Doctor: _____

Preferred Pharmacy: (*Include city and street or street intersection*):

Name: _____ City/Street: _____ Phone (if known): _____

CONTINUED ON BACK

Height and Weight: Height: _____ Weight: _____

PAST MEDICAL HISTORY (Circle all that apply):

Anxiety	COPD	Hypertension	Prostate Cancer
Arthritis	Coronary Artery Disease	HIV/AIDS	Radiation Treatment
Asthma	Depression	Hypercholesterolemia	Seizures
Atrial Fibrillation	Diabetes	Hy**PER**thyroidism	Stroke
Bone Marrow Transplant	End-Stage Renal Disease	Hy**PO**thyroidism	Other(s):
Benign Prostate Hyperplasia	GERD	Leukemia	_____
Breast Cancer	Hearing Loss	Lung Cancer	_____
Colon Cancer	Hepatitis	Lymphoma	

PAST SURGERIES: (*Circle all that apply and indicate year, if known*)

Appendix (Removal)

Bladder (Cystectomy)

Breast:
- Breast Biopsy
- Lumpectomy
  - Both / Left / Right
- Mastectomy
  - Both / Left / Right

Colon:
- Colectomy for:
  - Cancer Resection
  - Diverticulitis
  - Inflammatory Bowel Disease
  - Colostomy

Gallbladder (Removal)

Heart:
- Biological Valve Replacement
- Coronary Artery Bypass Surgery
- Heart Transplant
- Mechanical Valve Replacement
- Heart Cath (PTCA) – Stents?

Joint Replacement:
- Hip
  - Both / Left / Right
- Knee
  - Both / Left / Right

Kidney:
- Kidney biopsy
- Kidney *Stone* Removal
- Kidney Transplant
- Kidney Removal

Liver:
- Liver removal
- Liver Transplant
- Shunt

Ovaries:
- Removal of ovaries for:
  - Endometriosis
  - Ovarian Cancer
  - Ovarian Cyst
  - Tubal Ligation

Pancreas (Removal)

Prostate: (Removal)
- Prostate Biopsy
- Prostate Cancer
- TURP

Rectum:
- Abdominoperineal resection
- Low Anterior Resection

Skin:
- Skin Biopsy
- Basal Cell Carcinoma
- Squamous Cell Carcinoma
- Melanoma

Spleen (Removal)

Testicles (Removal)

Uterus: (Removal)
- Fibroids
- Uterine Cancer
- Cervical Cancer

Other_____

CONTINUED ON NEXT PAGE

Have you had any of the following skin conditions? (*Circle all that apply*)

Acne	Dry Skin	Poison Ivy
Actinic keratosis	Eczema	Precancerous moles
Asthma	Flaking or itchy scalp	Psoriasis
Basal cell cancer	Hay fever/Allergies	Squamous Cell Cancer
Blistering Sunburns	Melanoma	Other(s): _____

Do you wear sunscreen? NO YES **If yes, indicate the SPF used**: _____

Do you tan in a tanning salon? NO YES

Family History Please indicate if you have a family history of the following:

Melanoma? _____ If yes, which relative(s)? _____

Other Skin Cancers? _____ If yes, which relative(s)? _____

Other Diseases? _____ If yes, which relative(s)? _____

Medications: (*Please list **(name/dosage/route/frequency)*** or *provide us your medication list*)

1. *Name* _____ *Dosage:* _____ *Route:* _____ *Frequency:* _____
2. *Name* _____ *Dosage:* _____ *Route:* _____ *Frequency:* _____
3. *Name* _____ *Dosage:* _____ *Route:* _____ *Frequency:* _____
4. *Name* _____ *Dosage:* _____ *Route:* _____ *Frequency:* _____
5. *Name* _____ *Dosage:* _____ *Route:* _____ *Frequency:* _____
6. *Name* _____ *Dosage:* _____ *Route:* _____ *Frequency:* _____
7. *Name* _____ *Dosage:* _____ *Route:* _____ *Frequency:* _____
8. *Name* _____ *Dosage:* _____ *Route:* _____ *Frequency:* _____
9. *Name* _____ *Dosage:* _____ *Route:* _____ *Frequency:* _____

Medication Allergies/Reaction: (*Please indication allergies to medications and your **reaction***)

☐ No Known Drug Allergies _____

_____

Alcohol Use:

Male: How many times in the last year did you have 5 or more drinks in a day? _____

Female: How many times in the last year did you have 4 or more drinks in one day? _____

Smoking (Circle One): Never Former Currently: #packs/day_____ Total Yrs. Smoking: _____

CONTINUED ON BACK

Do you have any of the following *(Please circle all that apply)*:

Problems with healing	Chest pain	Neck Stiffness
Problems with scarring	Sore Throat	Headaches
Rash	Blurry Vision	Seizures
Hay Fever	Abdominal Pain	Cough
Fever/Chills	Bloody Stool	Shortness of Breath
Night Sweats	Bloody Urine	Wheezing
Unintentional Weight Loss	Joint Aches	Anxiety
Thyroid problems	Muscle Weakness	Depression

Do any of the following apply to you:

Allergy to latex	Rapid heartbeat with epinephrine
Defibrillator	Allergy to topical antibiotic ointments
Pacemaker	MRSA
Blood Thinner	Pregnancy or planning a pregnancy
Artificial heart valve	Problems with bleeding
Artificial joints **within the past 2 years**	Immunosuppression
Premedication prior to procedures	History of Hepatitis
Allergy to adhesive	History of HIV
Allergy to lidocaine	

REQUIRED QUESTIONS:

1) Would you allow a medical student and/or resident physician to observe during your visit? YES NO

2) Have you received the Flu Immunization in the last year? YES NO, if not why? _____

For Patients 65 and older :

3) Have ever received a pneumonia vaccination? YES NO, if not why? _____

4) Do you have a surrogate decision maker? NO YES: please provide name and phone number below

_____ _____

Surrogate Decision Maker Name Phone Number

Primary Insurance Information

Name of Primary Ins. Policy: _____ Insurance Policy No.:_____

Group Number :_____ Insurance Phone Number : _____

Subsriber Name: _____ Subscriber DOB: _____

Subscribers Relationship to Patient:_____

Secondary Insurance Information

Name of Secondary Ins. Policy: _____ Insurance Policy No.:_____

Group Number :_____ Insurance Phone Number : _____

Subsriber Name: _____ Subscriber DOB: _____

Subscribers Relationship to Patient:_____