DELUKE DERMATOLOGY
Medical and Cosmetic Dermatology

Welcome to DeLuke Dermatology!
Please fill out the Patient Registration Form Below

First Name:_____Last Name_____ Date of Birth:_____ Sex: Male/Female

Preferred Language: _____Race: _____ Ethnic Group: Hispanic/Latino or Not Hispanic/Latino

Preferred Phone Number: _____ Circle Type: Home/Mobile/Work

Alternative Phone Number: _____ Circle Type: Home/Mobile/Work

Would you like to receive a phone call or text message appointment reminder? ☐ Text Message ☐ Phone Call

Is it OK to leave a detailed voicemail? ☐ YES ☐ NO

Email Address: _____

Street Address: _____City / State: _____Zip _____

Emergency Contact Name: _____Phone Number_____

Health Insurance

Name of Health Insurance(s): _____

Insurance I.D.# _____

Policy Holder Name: _____

Policy Holder D.O.B. _____

Preferred Pharmacy

Name: _____Phone Number:_____

Address:_____

Referring Provider (if applicable)

Name:_____Specialty:_____

Phone Number:_____

Primary Care Physician

Name:_____

Phone Number:_____

Please list with whom we may discuss any medical condition or appointment detail. (First & last name, relation to patient)

_____ _____

_____ _____

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First Name:_____Last Name_____ Date of Birth:_____ Sex: Male/Female

Occupation and Workplace:

_____

Past Medical History- Please select all that apply

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

_____

_____

Medications _____

_____

_____

Allergies

List all allergies and reactions if known: _____

_____

_____

Past Surgical History- Have you had any surgeries on the following organs?

- ❑ Appendix (Appendectomy)
- ❑ Bladder (Cystectomy)
- ❑ Breast: Breast Biopsy
- ❑ Breast: Lumpectomy (Right, Left, Bilateral)
- ❑ Breast: Mastectomy (Right, Left, Bilateral)
- ❑ Colon (Colectomy): Colon Cancer Resection
- ❑ Colon (Colectomy): Diverticulitis
- ❑ Colon (Colectomy): Inflammatory Bowel Disease
- ❑ Colon: Colostomy
- ❑ Gallbladder (Cholecystectomy)
- ❑ Heart:
  Circle Type: Coronary Artery Bypass Surgery/PTCA
  Heart Transplant/Mechanical Valve Replacement
- ❑ Joint Replacement: Hip (Right, Left, Bilateral)
- ❑ Joint Replacement: Knee (Right, Left, Bilateral)
- ❑ Kidney:
  Circle Type: Kidney Biopsy/Nephrectomy/
  Kidney Stone Removal/Kidney Transplant
- ❑ Liver: Hepatectomy
- ❑ Liver: Liver Transplant
- ❑ Liver: Shunt
- ❑ Ovaries (Oophorectomy):
  Circle Type: Endometriosis/Ovarian Cancer/
  Ovarian Cyst/Tubal Ligation
- ❑ Pancreas: Pancreatectomy
- ❑ Postate (Prostatectomy): Prostate Biopsy
- ❑ Prostate (Prostatectomy: Prostate Cancer
- ❑ Prostate (Prostatectomy): TURP
- ❑ Rectum: APR
- ❑ Rectum: Low Anterior Resection
- ❑ Skin
  Circle Type: Melanoma/Basal Cell Carcinoma/
  Squamous Cell Carcinoma
- ❑ Spleen (Splenectomy)
- ❑ Testicles (Orchiectomy)
- ❑ Uterus (Hysterectomy)
  Circle Type: Fibroids/Uterine Cancer/Cervical Cancer
- ❑ NONE
- ❑ Other

_____

_____

_____

Skin Disease History

Have you had any of the following?

- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Asthma
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever / Allergies
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Precancerous Moles
- ❑ Psoriasis
- ❑ Squamous Cell Skin Cancer
- ❑ NONE
- ❑ 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?

_____

Do you have a family history of basal cell skin cancer?

❑ Yes ❑ No

If yes, which relative?

_____

Do you have a family history of squamous cell skin cancer?

❑ Yes ❑ No

If yes, which relative?

_____

Review of Systems: **Do you currently or have you recently had these symptoms?**

Symptom	Yes	No	Symptom	Yes	No
Problems with bleeding	❑	❑	Abdominal Pain	❑	❑
Problems with healing	❑	❑	Bloody Stool	❑	❑
Problems with scarring	❑	❑	Bloody Urine	❑	❑
Rash	❑	❑	Joint Aches	❑	❑
Immunosuppression	❑	❑	Muscle Weakness	❑	❑
Hay Fever	❑	❑	Neck Stiffness	❑	❑
Chest Pain	❑	❑	Headaches	❑	❑
Fevers or Chills	❑	❑	Seizures	❑	❑
Night Sweats	❑	❑	Cough	❑	❑
Unintentional Weight Loss	❑	❑	Shortness of Breath	❑	❑
Thyroid Problems	❑	❑	Wheezing	❑	❑
Sore Throat	❑	❑	Depression	❑	❑
Blurry Vision	❑	❑	Anxiety	❑	❑

Alerts

Conditions	Yes	No
Allergy to adhesive	❑	❑
Allergy to lidocaine	❑	❑
Artificial Heart Valve	❑	❑
Artificial Joints within last 2 years	❑	❑
Blood thinners	❑	❑
Defibrillator	❑	❑
MRSA	❑	❑
Pacemaker	❑	❑
Premedication Prior to Procedure	❑	❑
Rapid Heart Beat with Epinephrine	❑	❑
Pregnancy or planning a pregnancy	❑	❑