David C. Olansky, M.D.
Jodi E. Ganz, M.D.
Kelli Baender, M.D.
Humza Ilyas, M.D.
Jennifer Burger, M.D.
Sharon Doering, PA-C
Mary Benton Guthrie, PA-C
Julia Lee, PA-C

PLEASE ANSWER EACH QUESTION
(PRINT this form and bring with you to your appointment)

Patient Name: __________________________ Date of Birth: ____________ Appointment Date: _____________

Male ❑ Female: ❑ If NEW patient, how did you hear about us? _________________________________

Guarantor Name (if patient is a minor): ____

Address: ____Apt/Suite#_________________

City/State: ____ Zip Code: __________________

Contact Number: (Home) __________________________ (Mobile) _________________________

Email Address: ____

Preferred Language: ________________________

Race: ________________ Height: __________________ Weight: __________________________

Ethnicity: (circle one) Hispanic/Latino OR Non-Hispanic/Non-Latino

Do you have a Personal History of Skin Cancer? ❑ Yes ❑ No

If yes, which type? ❑ BASAL CELL ❑ SQUAMOUS CELL ❑ MELANOMA
Location: ____________ Location: ________________ Location: _____________

Do you have a history of HEPATITIS? ❑ Yes ❑ No If yes type: A ❑ B ❑ C ❑

Do you have HIV? ❑ Yes ❑ No

Do you have any known **DRUG ALLERGIES**? ____

Do you have any immediate relatives that have a history of skin cancer? ❑ Yes ❑ No

If yes, which type? ❑ BASAL CELL ❑ SQUAMOUS CELL ❑ MELANOMA

Do you use tanning beds? Yes ❑ or No ❑ If yes, CURRENT or PAST (circle one) How often per wk/month: _______

Do you use Sunblock? ALWAYS OCCASIONAL NEVER (circle one)

Do you use Alcohol? Yes ❑ or No ❑
If yes, how often: **Heavy** *(8 or more times per wk)* **MODERATE***(1-7 times per wk*) **OCCASIONAL** (1-2 times per month)

Have you used Tobacco? Yes ❑ or No ❑ If yes, CURRENT or PAST (circle one) WHAT KIND: _________

PLEASE COMPLETE PAGE 2 or REVERSE SIDE OF THIS FORM

Patient Name: ______________________________________ Date of Birth: _______________

Medication	Dosage	Reason for Taking

15. Are you Pregnant? YES or NO Are you trying to get pregnant? YES or NO

16. Are you Breastfeeding? YES or NO

17. Were you referred by a physician for today's visit? YES or NO if so, by whom:______________________________

18. Primary Physicians name and phone number: # ____

19. Pharmacy Name and Phone Number: # ____

Personal History

ARE YOU EXPERIENCING ANY OF THESE SYMPTOMS TODAY?

1. Fatigue ❑ Yes ❑ No
2. Fever ❑ Yes ❑ No
3. Weight Loss ❑ Yes ❑ No
4. Chills ❑ Yes ❑ No
5. Night Sweats ❑ Yes ❑ No
6. Headache ❑ Yes ❑ No
7. Cough ❑ Yes ❑ No
8. Difficult Breathing ❑ Yes ❑ No
9. Diarrhea ❑ Yes ❑ No
10. Joint Pain or Stiffness ❑ Yes ❑ No
11. Visual Changes ❑ Yes ❑ No
12. Unexplained or Easy Bruising ❑ Yes ❑ No
13. Excessive Bleeding ❑ Yes ❑ No

Reason for Today's Visit:

____

Form Completed by: ____Appointment Date: __________________