David C. Olansky, M.D.
Jodi E. Ganz, M.D.
Kelli Baender, M.D.
Humza Ilyas, M.D.
Jennifer Burger, M.D.
Sonya Bellamy, M.D.
Amanda Harpring, 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 (relationship)___________ ❑ 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: _________

Flu Vaccine: Yes ❑ (year taken)_______ No ❑ Pneumonia Vaccine: Yes ❑ (year taken)_______ No ❑

PLEASE COMPLETE PAGE 2 or REVERSE SIDE OF THIS FORM

Patient Name: ______________________________________ Date of Birth: _______________

Medication	Dosage	Reason for Taking/Condition

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: __________________