BEAIRD
dermatology

Patient's Name:	Date of Birth:	Height:	Weight:
Primary Care Physician:	Pharmacy:	Mail Order:	
Allergies: YES NO	If yes, please list:		
Medications: YES NO	If yes, please list:		

Past Medical History: Select any of the following medical conditions that you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Dx
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Dx
- ☐ Elevated Blood Pressure
- ☐ Elevated Cholesterol
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Lung Cancer
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None

Past Surgeries:

- ☐ Appendectomy
- ☐ Cholecystectomy
- ☐ Caesarean Section
- ☐ Excision of Basal Cell Carcinoma
- ☐ Excision of Melanoma
- ☐ Excision of Squamous Cell Carcinoma
- ☐ Hysterectomy
- ☐ Other:_____

Skin Conditions: Select any of the following skin conditions that you currently have/had:

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Carcinoma
- ☐ Eczema
- ☐ Itching Scalp
- ☐ Hay Fever/Allergies
- ☐ Malignant Melanoma
- ☐ Psoriasis
- ☐ Rash
- ☐ Squamous Cell Carcinoma
- ☐ None

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 non-melanoma skin cancer? YES NO		If yes, which relative and type of skin cancer?

Men: How many times in the past year have you had 5 or more drinks in a day: _____

Women and adults older than 65: How many times in the past year have you had 4 or more drinks in a day? _____

Smoking Status

- ☐ Current Everyday Smoker
- ☐ Former Smoker
- ☐ Never Smoker

Alcohol Consumption

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Social History Details

- ☐ Not sexually active
- ☐ Sexually active with one partner
- ☐ Sexually active with more than one partner

Influenza (Flu) Vaccine - Select the one that best fits:

- ☐ Received a flu vaccine this season
- ☐ Did NOT receive a flu vaccine this season

Pneumococcal Vaccine (for patients 65 and older ONLY):

- ☐ Received a Pneumococcal vaccine (Pneumovax)
- ☐ Did NOT receive a Pneumococcal vaccine

Other Vaccines (for patients who are EXACTLY 13 years old):

- ☐ Received one dose of meningococcal vaccine on or between 11-13th birthday.
- ☐ Received one tetanus, diphtheria and pertussis vaccine (Tdap) on or between 10th and 13th birthday.
- ☐ Received at least three HPV vaccines on or between my 9th and 13th birthday.

Advanced Directives:

Advances directives are designed to respect your autonomy and determine your wishes about future life-sustaining medical treatment if you are unable to indicate your wishes. Key interventions and treatment decisions are: resuscitation procedures such as Cardiopulmonary Resuscitation (CPR) and mechanical respiration (breathing tube).

Which statements(s) **best reflects** your wishes on advanced care recommendations?

- ☐ **Full Code:** I want full cardiopulmonary resuscitation efforts to be made.
- ☐ **Do not Intubate:** I do not wish to have a breathing tube, even it is necessary to save my life.
- ☐ **Do not Resuscitate:** If my heart were to stop, I do not wish to have chest compressions or automated defibrillator to restart my heart even if it's necessary to save my life.
- ☐ **I have a living will.**
- ☐ I have a **healthcare proxy** whose name is _____, and their phone number is _____.