



NASHVILLE SKIN & CANCER

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Gender M F SSN _____ Marital Status _____

Primary Phone _____ Work Phone _____ Secondary Phone _____

Street Address _____

City _____ State _____ ZIP _____ E-Mail _____

Primary Care Physician _____ Your Employer _____

Preferred Pharmacy & Location _____

Primary Insurance _____ Name of Policy Holder _____

Policyholder's DOB _____ Policyholder's SSN _____ Relation _____

If Different, Address _____ Phone Number _____

Secondary Insurance _____ Name of Policy Holder _____

Policyholder's DOB _____ Policyholder's SSN _____ Relation _____

If Different, Address _____ Phone Number _____

I may be contacted by the clinic at (check all that apply): ___ home ___ work ___ cell ___ e-mail

Messages regarding health information _____ may _____ may not be left on an answering machine.

Were you referred to us by another physician? ___ yes ___ no If yes, who? _____

Past Medical History (check all that apply): ___ skin cancer (indicate type below)

- ___ melanoma ___ basal cell carcinoma ___ squamous cell carcinoma
- ___ psoriasis ___ eczema ___ lupus ___ scleroderma ___ atypical moles
- ___ diabetes ___ heart attack ___ stroke ___ blood clot ___ atrial fibrillation
- ___ seizures ___ thyroid prob. ___ anemia ___ emphysema ___ high blood pressure
- ___ hepatitis B ___ hepatitis C ___ HIV ___ tuberculosis ___ bleeding problems
- ___ other (please describe) _____

Have you had cancer other than skin cancer? ___ yes ___ no If yes, what type? _____

Have you had an organ transplant? ___ yes ___ no If yes, what type? _____

Have you had a heart valve replacement? ___ yes ___ no

Have you had a joint replacement (knee, hip, etc.)? ___ yes ___ no

Do you have a pacemaker or defibrillator? ___ yes ___ no

FEMALES ONLY

Are you currently pregnant? ___ yes ___ no Currently breastfeeding? ___ yes ___ no

CONTINUED ON REVERSE SIDE

Current Medications (including vitamins and over-the-counter):

1. _____ 2. _____ 3. _____ 4. _____
 5. _____ 6. _____ 7. _____ 8. _____

Are you on any blood thinners? yes no
aspirin coumadin plavix vitamin E

Medication allergies (list all that apply): 1. _____ 2. _____

3. _____ 4. _____ 5. _____ 6. _____

Family History (please indicate any conditions present in immediate family):

melanoma yes no If yes, relation _____
 psoriasis yes no If yes, relation _____
 lupus yes no If yes, relation _____
 cancer yes no If yes, type and relation _____
 other yes no If yes, what and relation _____

Social History:

Do you smoke? yes no If yes, how many years? _____

Do you consume alcohol on a regular basis? yes no

Review of Systems:

Please indicate any symptoms you have recently experienced (check all that apply):

<input type="checkbox"/> fever	<input type="checkbox"/> chills	<input type="checkbox"/> night sweats	<input type="checkbox"/> weight loss
<input type="checkbox"/> headache	<input type="checkbox"/> seizures	<input type="checkbox"/> dizziness	<input type="checkbox"/> numbness
<input type="checkbox"/> nose bleeds	<input type="checkbox"/> mouth ulcers	<input type="checkbox"/> dry eyes	<input type="checkbox"/> blurred vision
<input type="checkbox"/> chest pain	<input type="checkbox"/> palpitations	<input type="checkbox"/> swollen legs	<input type="checkbox"/> enlarged lymph nodes
<input type="checkbox"/> coughing	<input type="checkbox"/> wheezing	<input type="checkbox"/> bloody sputum	<input type="checkbox"/> shortness of breath
<input type="checkbox"/> nausea	<input type="checkbox"/> vomiting	<input type="checkbox"/> diarrhea	<input type="checkbox"/> abdominal pain
<input type="checkbox"/> blood in urine	<input type="checkbox"/> urinary pain	<input type="checkbox"/> genital sores	<input type="checkbox"/> frequent urination
<input type="checkbox"/> arthritis	<input type="checkbox"/> muscle aches	<input type="checkbox"/> muscle cramp	<input type="checkbox"/> easy bleeding
<input type="checkbox"/> hair loss	<input type="checkbox"/> excess hair	<input type="checkbox"/> inc. sweating	<input type="checkbox"/> irregular menses
<input type="checkbox"/> anxiety	<input type="checkbox"/> depression	<input type="checkbox"/> fatigue	<input type="checkbox"/> suicidal thoughts

I, the undersigned, authorize Nashville Skin & Cancer and staff to provide medical service to me and authorize the disclosure of protected health information for purpose of payment, health care operations, and treatment.

_____	_____	_____	_____
Signature of Patient or Responsible Party	Date	Physician signature	Date