NORTHERN OKLAHOMA
DERMATOLOGY

Patient Name:_____ (Preferred Name)_____

Address:_____
Street City State Zip

Home Phone:_____ Cell Phone:_____ Email:_____

Date of Birth:_____ Social Security #:_____ Male or Female

Race and Ethnicity:_____ Language Spoken:_____ Marital Status: S M W D

In Case of Emergency Contact:_____
Name Phone

Primary Care Physician:_____ Referred By:_____
Name City/State Name City/State

Pharmacy:_____

Employer:_____ Full Time/Part Time/Retired Phone:_____

***Responsible Party/Parent or Guardian Information if under 18**

Name:_____ Date of Birth:_____ SSN:_____

Home Phone:_____ Cell Phone:_____

Address:_____
Street City State Zip

I assign directly to Northern Oklahoma Dermatology, LLC all insurance and/or Medicare benefits payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance and/or Medicare. I authorize the use of my signature on all insurance and/or Medicare submissions. The above named medical practice may use health care information and disclose such information for the purpose of obtaining payment from insurance and/or Medicare. This consent will end upon my providing a written revocation of the consent.

Patient Signature:_____ **Date**_____

PAST MEDICAL HISTORY

- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ COPD
- ☐ Colon Cancer
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Problems: Hyper or Hypo
- ☐ Other:_____

PAST SURGICAL HISTORY

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (R, L, Both)
- ☐ Colon Surgery
- ☐ Gall Bladder Removed
- ☐ Coronary Artery Bypass
- ☐ Heart Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement_____
- ☐ Kidney Removed (R, L)
- ☐ Kidney Transplant
- ☐ Ovaries Removed (Cancer)
- ☐ Prostate Removed (Cancer)
- ☐ Spleen Removed
- ☐ Testicles Removed (R, L, Both)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Tonsillectomy
- ☐ None
- ☐ Other_____

SKIN DISEASE HISTORY

- ☐ Acne
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Eczema
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Sunburn of second degree
- ☐ Other_____
- ☐ None

Do you have a family history of Melanoma? **Yes/No.** If yes, Which relatives? _____

Do you have a healthcare Proxy? Yes/No

65 and Older have you received the Pneumonia Shot? Yes/No

Have you received the Influenza Vaccine past 12 months? Yes/No

Medications: (List all current medications, **including dosage and frequency** or give list to staff to copy)

Medication Name	Dosage	Frequency

Allergies: (List all allergies)

_____

_____

Family History: (Only first degree relatives with relation to you)

_____

_____

SOCIAL HISTORY

☐ Currently smoke/ Vape ☐ Former smoker ☐ Never smoked

Do you consume alcohol? ☐ Yes ☐ No If Yes, how often? ☐ Occasionally ☐ Frequently

REVIEW OF SYSTEMS

Are you currently experiencing any of the following?

Problems with bleeding	☐ Yes	☐ No	Unintentional weight loss	☐ Yes	☐ No
Problems with healing	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Problems with scarring	☐ Yes	☐ No	Joint aches	☐ Yes	☐ No
Rash	☐ Yes	☐ No	Muscle weakness	☐ Yes	☐ No
Immunosuppression	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No	Anxiety/Depression	☐ Yes	☐ No
Fever or Chills	☐ Yes	☐ No	Other_____		

ALERTS

- ☐ Allergy to adhesive
- ☐ Allergy to Lidocaine
- ☐ Blood thinners
- ☐ Pacemaker
- ☐ Pregnant
- ☐ Trying to become pregnant

Describe skin problem:_____

Area of skin problem:_____

How long have you had this problem:_____ Have you had this problem in the past: ☐ Yes ☐ No

Does anyone in your family have this problem: ☐ Yes ☐ No If Yes, who:_____