PLEASE BRING CURRENT GOVERNMENT ISSUED PICTURE IDENTIFICATION AND INSURANCE CARD(S) AT TIME OF YOUR APPOINTMENT. PAPERWORK NEEDS TO BE FILLED OUT & RECEIVED BY APPOINTMENT TIME OR WE MAY NEED TO RESCHEDULE YOUR APPOINTMENT.

DATE _____
FIRST NAME _____M.I._____LAST NAME_____ DOB_____
SS#_____SEX____MARITAL STATUS_____E-MAIL_____
PHYSICAL ADDRESS_____ CITY _____ZIP _____
MAILING ADDRESS _____ CITY _____ZIP _____
HOME PHONE _____CELL PHONE_____WORK_____
PREFERRED METHOD OF CONTACT _____
EMPLOYER_____ OCCUPATION _____EMPLOYER'S PHONE_____
REFERRED BY_____ PRIMARY CARE PHYSICIAN_____
***** May we leave personal medical information on your answering machine or cell phone? Yes___ No___**

RACE_____ PREFER NOT TO ANSWER_____
ETHNICITY: Hispanic ____ Not Hispanic ____ PREFER NOT TO ANSWER_____
LANGUAGE_____ PREFER NOT TO ANSWER_____

RESPONSIBLE PARTY/GUARDIAN _____DOB_____RELATIONSHIP_____

PRIMARY INSURANCE COMPANY_____ ID# _____
SUBSCRIBER'S NAME_____DOB _____Relationship _____
SUBSCRIBER'S MAILING ADDRESS (IF DIFFERENT) _____ CITY _____ZIP _____
SECONDARY INSURANCE COMPANY _____ ID# _____
SUBSCRIBER'S NAME_____DOB _____Relationship_____
SUBSCRIBER'S MAILING ADDRESS (IF DIFFERENT) _____ CITY _____ZIP _____
SEPARATE PRESCRIPTION INSURANCE_____

EMERGENCY CONTACTS:
NAME_____RELATIONSHIP_____PHONE_____
WHO IS IT OK TO DISCUSS MEDICAL INFORMATION WITH?
NAME_____RELATIONSHIP_____PHONE_____

Electronic Prescription Download
The privacy of your personal health information contained in all your prescriptions is protected by a federal law, HIPAA, and state laws. Your personal health information can only be shared for the purpose of providing you with clinical care. E-prescriptions meet this requirement. I also authorize Brune Dermatology to release my medical information to another physician, hospital, pharmacy, or medical care facility as needed to facilitate treatment. I furthermore will allow my pharmacy to supply verification of benefits.
** **If you require a mail order pharmacy, you MUST provide us with a fax number.**

Pharmacy_____Location_____

***** Do you have a living will? Yes____ No____**
Do you have a healthcare proxy in the event you are unable to make your own medical decisions? Yes___ No____
If yes, who? _____
Would you like to be added to our cosmetic email list? Yes_____ No_____

CONTINUED ON NEXT PAGE-

MEDICAL HISTORY FORM

*****IMPORTANT: PLEASE ANSWER AS COMPLETE AS POSSIBLE*****

NAME_____

AGE_____ WEIGHT _____lbs. HEIGHT _____ft._____in.

*****Have you received a flu shot this year? Y/N When? _____**

*****Have you received a pneumonia shot in the last 5 years? Y/N When? _____**

MEDICAL HISTORY (Illnesses you have or you had in the past, check all that apply)

☐ Allergies / Hay fever	☐ Atypical moles	☐ Hepatitis / Liver disease	☐ Keloids
☐ Arthritis	☐ Diabetes	☐ High Blood Pressure	☐ Kidney disease
☐ Asthma	☐ Depression	☐ High Cholesterol	☐ Pacemaker
☐ Autoimmune disease	☐ Eczema	☐ HIV	☐ Thyroid disease
☐ Artificial joints or heart valves _____		☐ Tuberculosis	☐ Positive TB Skin Test (PPD)
☐ Heart Attack			

☐ Other_____

☐ Skin Cancer: Basal Squamous Melanoma

☐ Other Cancer _____

☐ History of sunburns ☐ Blistering Sunburn

☐ History of tanning beds use (present or past)

FAMILY HISTORY (Circle all that apply and list relationship)

Melanoma? ☐ Who?	Precancerous Mole?	Eczema?	Psoriasis?	Other skin cancers?	Genetic disease?

LIST THE MEDICATIONS YOU ARE TAKING

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGY TO MEDICATIONS:

_____

SOCIAL HISTORY (Check all that apply)

Ever Smoked?	For how long?	Packs a day?	Quit when?	Do you drink alcohol?	How many drinks/day?

CONTINUED ON NEXT PAGE-

Within the last 2-3 days, have you experienced any of the following symptoms?

Constitutional
__yes chills
__yes fatigue
__yes fever
__yes loss of appetite
__yes weight loss

Head, Eyes, Ears, Nose, Throat
__yes dry eyes
__yes visual disturbance
__yes dry mouth
__yes bloody nose
__yes hearing loss
__yes mouth sores
__yes sore throat
__yes difficulty swallowing
__yes taste change
__yes ringing ears

Cardiovascular
__yes chest pain
__yes edema
__yes palpitations

Respiratory
__yes cough
__yes cough up blood
__yes difficulty breathing

Gastrointestinal
__yes abdominal pain
__yes hemorrhoids
__yes constipation
__yes diarrhea
__yes heartburn/indigestion
__yes nausea
__yes rectal pain
__yes vomiting

Immunologic
__yes immune deficiency
__yes frequent infections

Genitourinary
__yes bladder disease
__yes painful urination
__yes blood in urine
__yes kidney disease

Musculoskeletal
__yes joint pain
__yes back pain
__yes muscle weakness
__yes swollen joints

Neurologic
__yes confusion
__yes dizziness
__yes epilepsy
__yes headache
__yes loss of consciousness
__yes memory loss
__yes numbness
__yes seizure
__yes stroke
__yes vertigo

Psychiatric
__yes depression
__yes insomnia
__yes anxiety

Skin
__Rash
__ Lumps
__Itching
__Dryness
__Color changes
__Hair and nail changes

Signature of Patient or Guardian_____