Dermatology & Skin Surgery Center, PA

David Adam Kiken, MD, FAAD

Diplomate of the American Board of Dermatology

Today's date:______________________________

PATIENT INFORMATION

Last name: ______________________________ First Name: ______________________________

Date of birth:______________________________ Gender: M__ F__ Marital: S __ M __ W__ D___

Address: ____

Social Security #: ______________________________Home Phone: ______________________________

Occupation: ______________________________ Work Phone:______________________________

Cell Phone: ______________________________ Email: ______________________________

Emergency Contact:

Name: ______________________________ Phone(s) ______________________________

Address: ______________________________ ______________________________

Primary Care Physician (name & phone #): ______________________________

Referring doctor, if applicable (name & phone #)______________________________

Other referral source (friend, ad, website, etc.): ______________________________

CURRENT SKIN PROBLEMS Please explain the reason(s) for today's visit ... (skin concerns, check-up, cosmetic)

1. ____

   Site______________________________ How long has it been going on?______________________________

   Severity ______________________________Any past treatment______________________________

2. ____

   Site______________________________ How long has it been going on?______________________________

   Severity ______________________________Any past treatment______________________________

3. ____

   Site______________________________ How long has it been going on?______________________________

   Severity ______________________________Any past treatment______________________________

MEDICATIONS AND MEDICATION ALLERGIES

List all of the oral and/or topical medications that you use, including vitamins, herbal supplements, over-the-counter medications.

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Allergies to medications (pills, injectable drugs, creams and lotions, etc.) ______________________________

____

Your primary pharmacy:

Name ______________________ Town ______________________ Phone ______________________

SOCIAL HABITS

Alcohol Use:	O Yes	O No	How much? ____________	Quit? When ________
Street Drugs:	O Yes	O No	How much? ____________	Quit? When ________
Smoking:	O Yes	O No	How much? ____________	Quit? When ________

PERSONAL SKIN HISTORY

Please check Y for Yes or N for No if you have or have had any of the following conditions:

Condition			Condition		
Actinic Keratosis “precancer”)	NO	YES	Lupus, erythematosus	NO	YES
Acne	NO	YES	Psoriasis	NO	YES
Excessive hair growth	NO	YES	Pigmentary problems	NO	YES
Excessive sweating	NO	YES	Rosacea	NO	YES
Eczema or Atopic Dermatitis	NO	YES	Keloid scarring	NO	YES

Have you ever had skin cancer? O Yes O No If so, in what year ________ site ____________

Please indicate type: O Basal Cell O Squamous Cell O Melanoma O Other

Have you ever had any other skin conditions? ______________________________________

OTHER PAST MEDICAL HISTORY

Do you have a history of asthma? O Yes O No

Have you had seasonal allergies or hay fever? O Yes O No

Have you ever had cold sores (Herpes Simplex Infection)? O Yes O No

For Women: Are you pregnant? O Yes O No

If you are nursing, are you breast feeding? O Yes O No

Are you using Birth Control? O Yes O No

If so, indicate method(s) O Oral Contraceptive Pills O Condoms O Depo Provera O Implanted Device O Other

FAMILY HISTORY

Please check Yes or N if you have a family history of any of the following conditions:

Condition	NO	YES	Condition	NO	YES
Acne	NO	YES	Rheumatoid Arthritis	NO	YES
Basal Cell Carcinoma	NO	YES	Lupus, erythematosus	NO	YES
Squamous Cell Carcinoma	NO	YES	Psoriasis	NO	YES
Melanoma	NO	YES	Pigmentary problems	NO	YES
Eczema	NO	YES	Rosacea	NO	YES

Other family medical history (skin conditions and/or other conditions): ______________________________

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GENERAL MEDICAL HISTORY

Please list all previous or current medical problems, illnesses and major diagnoses, along with the dates thereof.

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Please list all previous surgeries and other medical procedures you have undergone, along with the dates thereof.

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SYMPTOM REVIEW

Are you currently having problems in any of the areas below? If so, circle each area in which you have a problem.

Allergies	Fevers, chills, sweats	Male reproductive organs
Bleeding	Thyroid / other endocrine	Joints / Back / Neck
Breathing	Eye(s)	Neurological
Heart	Stomach	Mood / Psychiatric
Weight loss or gain	Female reproductive organs	Ears / Nose / Throat

REVIEW OF SYSTEMS

Do you have trouble with wound healing? O Yes O No

Do you tend to bleed excessively? O Yes O No

Do you have a tendency to form hypertrophic scars and keloids? O Yes O No

Have you had allergic reactions to bandages and tape? O Yes O No

Do you have enlarged lymph nodes? O Yes O No

Are you immunosuppressed, e.g. have HIV/AIDS or a history of lymphoma or leukemia? O Yes O No

Do you have a prosthetic hip or knee joint? O Yes O No

Do you have a pacemaker/defibrillator? O Yes O No

Do you take aspirin or coumadin or other anticoagulants? O Yes O No

Do you have mitral valve prolapse? O Yes O No

Do you have a history of blood clots or emboli? O Yes O No

Have you ever fainted or become light-headed during minor surgical procedures? O Yes O No

Would you like information on (please circle):

Botox treatments Fillers (Restylane, Juvederm, Radiesse)

Scar treatments (e.g. acne scars)

Chemical peels (e.g. Jessner's, glycolic acid, TCA)

Spider and varicose vein treatment

Mesotherapy (fat-dissolving injections)

If you have any other concerns or comments, please note them here.

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Patient Signature:____ Date:____________________

Welcome to the

Dermatology & Skin Surgery Center, PA   Dr. David A. Kiken, M.D., FAAD

SIGNATURE-ON-FILE AND FINANCIAL AGREEMENT

I, ______________________________________, acknowledge that Dermatology & Skin Surgery Center, PA, will bill the insurance company about which I have provided information on the day of my visit, as a courtesy to me. However, as the patient, I am ultimately responsible for my medical bills if, for whatever reason, I become ineligible with this insurance company at the time of service, or if my insurance company denies payment for any reason for a service provided by Dermatology & Skin Surgery Center, PA.

____ ______________________

Patient Name Date