Clear Dermatology

Name: _____ 21785 Filigree Court, Suite 206, Ashburn, VA 20147 DOB: _____
(703) 996-4000 www.ClearDermVA.com

Full Name: _____DOB_____Gender: M/ F/ other
Mailing address _____
_____
Home phone _____Cell phone_____
Work phone_____Preferred number for contact: HOME/CELL/ WORK
** May we leave a message with medical information at the preferred number: YES/ NO
Current Occupation _____

Preferred pharmacy_____
Street and City of preferred pharmacy_____

Primary care physician (PCP) name: _____
Address of PCP (city if unknown): _____
Is this a consultation (were you sent by your PCP or other physician): YES/ NO
If yes to above, name of referring physician_____
Specialty and city of practice of referring physician_____
Did anyone else refer you to our specific practice? _____

EMERGENCY CONTACT

Emergency Contact Name and Relationship: _____
Emergency Contact Phone Number_____

INSURANCE:

Primary Insurance _____
Ins ID#_____Ins Group #_____
Name of Insured_____Insured DOB_____
Insured SSN_____Patient SSN_____

Secondary Insurance _____
Ins ID#_____Ins Group #_____
Name of Insured_____Insured DOB_____
Insured SSN_____Patient SSN_____

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SKIN HISTORY:

Do you: ☐ Always burn ☐ Burn first and then tan ☐ Almost never burn Have you ever had a blistering sunburn, even as a child: ☐ YES ☐ NO
Have you ever used a tanning bed? ☐ YES ☐ NO
If yes, are you still using the? YES NO
How often is/was the use? ☐ sporadic ☐ regular (____ times per week for _____ months/ years) Do you develop thick scars or keloids after surgery? ☐ YES ☐ NO
Are you prone to herpes outbreaks (cold sores/fever blisters) around the mouth? ☐ YES ☐ NO
Does anything touching your skin (adhesives, medicated creams, etc) cause a rash? ☐ YES ☐ NO

REVIEW OF SYSTEMS (Mark any symptoms you are currently experiencing):

- ◯ Fevers/Chills
- ◯ Night Sweats
- ◯ Unusual Fatigue
- ◯ Unusual weight loss
- ◯ Unusual weight gain
- ◯ Difficulties with hot/cold temperature
- ◯ Loss of appetite
- ◯ Swollen glands
- ◯ Excessive sweating
- ◯ Flushing
- ◯ New onset headaches
- ◯ Feelings of depression
- ◯ Feelings of anxiety
- ◯ Vision changes
- ◯ Arthritis/ Joint pains
- ◯ Muscle aches
- ◯ Muscle weakness
- ◯ Stomach discomfort
- ◯ Nausea/ Vomiting
- ◯ Diarrhea
- ◯ Hair loss
- ◯ Unwanted hair growth
- ◯ Itching
- ◯ Rash
- ◯ Mouth sores
- ◯ Sore throat
- ◯ Genital sores
- ◯ Painful urination
- ◯ Changes in sensation in the hands/feet

FOR FEMALES ONLY (Mark any that apply):

- ◯ Irregular periods
- ◯ Breast feeding
- ◯ Pregnant
- ◯ Trying currently to get pregnant
- ◯ Difficulty getting pregnant
- ◯ On hormonal contraception

Date of last menstrual period: _____ Forms of birth control _____

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PERSONAL MEDICAL HISTORY (Mark any that apply):

- ◯ Acne
- ◯ Anemia
- ◯ Asthma
- ◯ Atypical mole biopsy
- ◯ Basal Cell Skin Cancer
- ◯ Bleeding disorder
- ◯ Blood clots
- ◯ Cancer (not skin, specify type _____)
- ◯ Cataracts/glaucoma
- ◯ COPD/ Lung issues
- ◯ Depression/Anxiety
- ◯ Diabetes
- ◯ Eczema
- ◯ Endocarditis
- ◯ Heart disease/Heart attack
- ◯ Hepatitis/ Liver problems
- ◯ High blood pressure
- ◯ High cholesterol
- ◯ HIV/AIDS
- ◯ Irregular heartbeat
- ◯ Kidney problems/ Dialysis
- ◯ Lupus or other connective tissue disease
- ◯ Melanoma (date _____)
- ◯ Mitral Valve Prolapse
- ◯ Nerve problems
- ◯ Psoriasis
- ◯ Seasonal allergies
- ◯ Seizure disorder
- ◯ Squamous Cell Skin Cancer
- ◯ Stroke
- ◯ Thyroid disease
- ◯ Transplant (organ and date _____)
- ◯ Tuberculosis
- ◯ Other _____ _____

Do you have or require any of the following:

- ◯ Artificial heart valves
- ◯ Artificial joints (date _____)
- ◯ Other metal implants (date _____)
- ◯ Pacemaker or defibrillator

Do you require antibiotics before procedures or dental cleanings? ☐YES ☐NO

Do take aspirin, coumadin, Plavix, Xarelto, Pradaxa or Eliquis? ☐YES ☐NO

Are you on any immunosuppressants? ☐YES ☐NO

Write a date for your last visit of the following (only if applicable):

- Dental exam _____
- Eye exam _____
- Colonoscopy _____
- Flu shot _____
- Pneumovax_____
- Pelvic exam _____
- Mammogram _____
- Prostate exam/PSA _____

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MEDICATIONS: [ ] Check if none

Medication Name	Dose	When you take it (ex: daily, two times a day, etc)	Injection (I) or Pill (P)

Do you take any over the counter medications or supplements regularly (Fish Oil, Tylenol, Advil, etc):

_____

_____

_____

Allergies to medications: ☐ Check if none

Medication/ substance	Reaction (ex. Hives, Rash, stopped breathing)

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FAMILY MEDICAL HISTORY (Please mark if any of the family has had any of the following):

	Mother	Father	Sibling	Child	Maternal grandmother	Maternal grandfather	Paternal grandmother	Paternal grandfather
Asthma								
Eczema								
Seasonal Allergies								
Heart disease								
Stroke								
Psoriasis								
Rosacea								
Melanoma								
Basal Cell Skin Cancer								
Squamous Cell Skin Cancer								
Other skin cancer								
Lupus								
Thyroid disease								
Other autoimmune								
Other cancer								
Other								

SOCIAL HISTORY:

Do you or have you smoked (cigarettes/ cigars/ pipes)? ☐ YES ☐ NO
If yes, how many packs per day? _____
Are you smoking now? ☐ YES ☐ NO
Do you or have you chewed tobacco? ☐ YES ☐ NO
Are you chewing tobacco now? ☐ YES ☐ NO
Do you or have you used any other drugs? ☐ YES ☐ NO
If yes, what kinds? _____
Do you drink alcohol? ☐ YES ☐ NO
If yes, how much? _____ drinks per _____
Do you have anyone at home who can help you with things? ☐ YES ☐ NO