GLAMDERM
GRAMERCY LASER AND MEDICAL DERMATOLOGY

A: 130 E. 18th street, Suite 1U, NY NY 10003 | P: 212-674-0004 | F: 917-677-8525
E: info@glamderm.com | W: www.glamderm.com

PATIENT INFORMATION AND MEDICAL HISTORY FORM

Welcome to our practice. As a new patient, please complete the following information to the best of your ability

PATIENT DEMOGRAPHICS

Last Name: ______________________ First Name: ______________________ MI: __________

Date of Birth: ______________________ Gender: __________ Social Security: ______________________

Occupation: ____

CONTACT

☐ Home: ______________ ☐ Work: ______________ ☐ Cell: ______________

May we leave a detailed message? ☐ Yes ☐ No If YES, please check preferred number.

Email:

Email is our preferred method of communication for appointment confirmations, test results, prescriptions/refills, and billing matters. Please initial here __________ to indicate that you are willing to receive email correspondence related to your care from the practice.

ADDRESS

Street Address: ____

City: ______________________ State: ______________________ Zip Code: __________

EMERGENCY CONTACT

Name: ______________________ Relationship: ______________________ Phone: __________

REFERRAL

How did you find us? ____

INSURANCE INFORMATION

Primary Insurance Company: ______________________ Plan: ______________________

Policy Number: ______________________ Group Number: ______________________

Insured Name: ______________________ Relationship to Card holder ______________________

Subscriber Information: (Policyholder if different from patient)

Relationship to Patient: __________ Name: ______________________ Date of Birth: __________

S.S. Number: ______________ Address: ______________ City/State/Zip: ______________

Phone Number: ______________ Employer's Name: ______________ Work Number: ______________

PREFERRED PHARMACY

In compliance with new health care regulations, we send prescription electronically. Please provide us with your pharmacy information below. If you do not have a pharmacy of record, we can either recommend one for you or help you find one that is convenient.

Name: ______________ Location: ______________ Zip: __________ Phone: ______________

I affirm that the above information is accurate and up to date:

Patient name (print) ______________________ Signature: ______________________ Date: __________

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PATIENT MEDICAL HISTORY

Name: ______ Gender: ______ Age: ______ Date of Appointment: ______

Reason for Visit

What brings you to the office today? ______

Allergies

Do you have any allergies? ______

Medications

Name	Dosage	Frequency

Skin

Do you have any of the following?

- ☐ Abnormal Moles
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell
- ☐ Blistering
- ☐ Sunburn
- ☐ Cold Sores
- ☐ Eczema
- ☐ Hives/Allergies
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Rosacea
- ☐ Scars
- ☐ Squamous Cell

Other ______

Have you ever had a biopsy for a suspicious growth?
☐ Yes ☐ No

Last full body exam ______

When you are exposed to the sun do you:
☐ Tan Only ☐ Tan and Burn ☐ Burn Only

Have you visited tanning salons or do you sunbathe?
☐ Yes ☐ No

Do you regularly apply sunblock to exposed areas?
☐ Yes ☐ No If yes, which SPF? ______

Have you ever had skin cancer?
☐ Yes ☐ No If yes, what type? ______

When? ______ Where? ______

Past Medical History

Have you ever had any of the following?

- ☐ Atrial fibrillation
- ☐ Asthma
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ AIDS/HIV
- ☐ Bleeding Disorder
- ☐ Bowel Disorder
- ☐ Diabetes
- ☐ Depression
- ☐ Heart Disease
- ☐ Hepatitis-A, B or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Lupus
- ☐ Malignancy
- ☐ Neurologic Disease
- ☐ Pacemaker or ICD
- ☐ Peptic Ulcer Disease
- ☐ Poly Cystic Ovaries
- ☐ Rheumatologic Disease
- ☐ Thyroid Disorder
- ☐ None

Current height ______ Current weight ______

Hospitalizations & Surgeries

Any complications with previous surgery? ☐ Yes ☐ No

Reason	Date

Require ABX before surgery of skin cancer? ☐ Yes ☐ No

Woman Only

Are you pregnant? ☐ Yes ☐ No
Are you breastfeeding? ☐ Yes ☐ No

Last menstrual period: ______

Lifestyle Factors

Have you ever smoked? ☐ Yes ☐ No

# of years ______ # packs/day ______

How much alcohol do you drink per week?

drinks/week ______

Family History

Has anyone in your family ever had any of the following conditions?

- ☐ Abnormal Moles
- ☐ Acne
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Basal Cell
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Skin Cancer
- ☐ Squamous Cell

Details: ______

* Please note that skin cancer screenings are comprehensive, full body examinations that require a separate visit

CONTINUE