Name:_____ Referring Physician:_____

Age:____ Birthdate:_____ Sex: ☐ **M** ☐ **F** Race: _____ Occupation: _____

Summarize your skin problems:

_____

_____

How long have you had your skin problem? _____

On what part of your body did the problem first start? _____

Has this skin disorder spread to other parts of the body? If so, please list them:

_____

Have you ever had a similar skin problem?_____

Do you have any of the following symptoms? ☐ No symptoms ☐ Itching ☐ Burning ☐ Pain
☐ Bleeding ☐ Drainage ☐ Nervousness / stress ☐ Chills ☐ Joint pains ☐ Fever
Other symptoms: _____

Do other members of your family or close associates have skin problems?

_____

What treatments have you had for your skin problems? (Include over-the-counter and prescribed therapy) Please be specific:

_____

Please list all medications you take (include over-the-counter and prescribed medicines):

MEDICATION	**REASON TAKEN**	**DATE STARTED**	**DATE STOPPED**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is your skin problem caused or aggravated by your job? ☐ **N** ☐ **Y** Sunlight? ☐ **N** ☐ **Y** Exposure to cold? ☐ **N** ☐ **Y**

Please list all known allergies (including medication):

_____

In the past, have you ever had any other skin problems? If so, please describe:

_____

Smoke? ☐ **N** ☐ **Y** Alcohol consumption: ☐ Occasionally ☐ Daily ☐ None

FOR WOMEN ONLY
Are you pregnant? ☐ **N** ☐ **Y** If yes, expected date of delivery?_____ Are you breastfeeding? ☐ **N** ☐ **Y**

CONSENT
Release of Information. I authorize **Associated Skin Care Specialists, P.A.** to disclose and furnish copies of any information relating to my care at **Associated Skin Care Specialists, P.A.** (including any information related to substance abuse, mental health, HIV/AIDS, or other sensitive issues), to:

- any person or health care provider **Associated Skin Care Specialists, P.A.** believes to be involved in my care;
- any person or organization that may request the records for study and research purposes, in accordance with **Associated Skin Care Specialists, P.A.** policy and applicable law (unless I object, in which case my records will not be released for research purposes);

In certain cases, such as when I request to have my records sent to another provider, I understand that **Associated Skin Care Specialists, P.A.** may charge me, and I agree to pay, a copying fee for **Associated Skin Care Specialists, P.A.** 's costs in. photocopying or otherwise reproducing the records.
Blood Tests. If an employee or other health care worker furnishing services on behalf of **Associated Skin Care Specialists, P.A.** is at any time exposed to my blood or bodily fluids through a needle stick or any other exposure incident, I agree to submit to a blood test at the request of **Associated Skin Care Specialists, P.A.** so that my blood may be tested for blood-borne diseases, including hepatitis and Human Immunodeficiency Virus (HIV, the virus that causes AIDS). In such case, **Associated Skin Care Specialists, P.A.** will furnish me with the results of the blood test and offer related health care services.

ASSOCIATED Skin Care Specialists, P.A.

Signature: _____ Date: _____

Date Reviewed:_____ Initials: _____ **Date Reviewed: _____ Initials: _____**