



*Academic* **DERMATOLOGY**  
*Cutaneous Surgery & Laser Center*



6545 France Ave S, Suite 564, Edina, MN 55435 952.746.6090

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ FirstName \_\_\_\_\_ Middle Initial \_\_\_\_\_ DOB \_\_\_\_\_

Marital Status \_\_\_\_\_ Sex: M F SSN \_\_\_\_\_

**RACE**

- American Indian or Alaska Native
- Asian
- Native Hawaiian or Pacific
- Black or African American
- White
- Hispanic
- Other

**ETHNICITY**

- Hispanic or Latin
- Non-Hispanic or Latin
- Other

Mailing Address \_\_\_\_\_

City/State/ZipCode \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email (at which you may receive communications from Academic Dermatology) \_\_\_\_\_

Occupation (if retired, former occupation) \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

City/State/ZipCode \_\_\_\_\_

Work Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

**PREFERRED PHARMACY**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZipCode \_\_\_\_\_

**EMERGENCY CONTACT**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**INSURANCE INFORMATION**

Ins Name \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber: Last Name \_\_\_\_\_ First Name \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Address(if different than patient's) \_\_\_\_\_

City/State/ZipCode \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**HOW DID YOU HEAR OF ACADEMIC DERMATOLOGY:**

(please check all that apply)

- YellowBook
- Dex
- Internet
- Referring Physician \_\_\_\_\_
- Friend or Family \_\_\_\_\_
- Other \_\_\_\_\_

**Academic Dermatology, PC**

**Date of Service:**

**Patient Name:**

**Date of Birth:**

Sexually active	<input type="radio"/> Yes <input type="radio"/> No	Pacemaker	<input type="radio"/> Yes <input type="radio"/> No
Frequent yeast infections	<input type="radio"/> Yes <input type="radio"/> No	High blood pressure	<input type="radio"/> Yes <input type="radio"/> No
Irregular menses	<input type="radio"/> Yes <input type="radio"/> No	Swelling of ankles	<input type="radio"/> Yes <input type="radio"/> No
Sexually Transmitted Diseases	<input type="radio"/> Yes <input type="radio"/> No	Irregular heart beat	<input type="radio"/> Yes <input type="radio"/> No
Pregnant	<input type="radio"/> Yes <input type="radio"/> No	Acid reflux	<input type="radio"/> Yes <input type="radio"/> No
Contraception	<input type="radio"/> Yes <input type="radio"/> No	Diarrhea	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/> Yes <input type="radio"/> No	Vomiting	<input type="radio"/> Yes <input type="radio"/> No
Memory loss	<input type="radio"/> Yes <input type="radio"/> No	Eczema	<input type="radio"/> Yes <input type="radio"/> No
Numbness	<input type="radio"/> Yes <input type="radio"/> No	Skin cancer	<input type="radio"/> Yes <input type="radio"/> No
Suicidal Thoughts	<input type="radio"/> Yes <input type="radio"/> No	Bruising	<input type="radio"/> Yes <input type="radio"/> No
Leg claudication	<input type="radio"/> Yes <input type="radio"/> No	Itching	<input type="radio"/> Yes <input type="radio"/> No
Muscle aches	<input type="radio"/> Yes <input type="radio"/> No	Vitiligo	<input type="radio"/> Yes <input type="radio"/> No
Joint surgery	<input type="radio"/> Yes <input type="radio"/> No	Excessive hair growth	<input type="radio"/> Yes <input type="radio"/> No
Photosensitivity	<input type="radio"/> Yes <input type="radio"/> No	Hair loss	<input type="radio"/> Yes <input type="radio"/> No
Raynaud's	<input type="radio"/> Yes <input type="radio"/> No	Psoriasis	<input type="radio"/> Yes <input type="radio"/> No
Joint pain	<input type="radio"/> Yes <input type="radio"/> No	Skin ulcer	<input type="radio"/> Yes <input type="radio"/> No
Kidney disease	<input type="radio"/> Yes <input type="radio"/> No	Fever	<input type="radio"/> Yes <input type="radio"/> No
Keloid formation	<input type="radio"/> Yes <input type="radio"/> No	Phlebitis	<input type="radio"/> Yes <input type="radio"/> No
Chills	<input type="radio"/> Yes <input type="radio"/> No	Atypical Mole	<input type="radio"/> Yes <input type="radio"/> No
Night sweats	<input type="radio"/> Yes <input type="radio"/> No	Rash	<input type="radio"/> Yes <input type="radio"/> No
Fatigue	<input type="radio"/> Yes <input type="radio"/> No	Hives	<input type="radio"/> Yes <input type="radio"/> No

Weight loss	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Leg edema	<input type="radio"/> Yes <input type="radio"/> No	Excessive sweating	<input type="radio"/> Yes <input type="radio"/> No
Varicose veins	<input type="radio"/> Yes <input type="radio"/> No	Kidney stones	<input type="radio"/> Yes <input type="radio"/> No
High cholesterol	<input type="radio"/> Yes <input type="radio"/> No	History of other skin disease	<input type="radio"/> Yes <input type="radio"/> No
Menopause	<input type="radio"/> Yes <input type="radio"/> No	Thyroid disorder	<input type="radio"/> Yes <input type="radio"/> No
Bleeding disorder	<input type="radio"/> Yes <input type="radio"/> No	Headache	<input type="radio"/> Yes <input type="radio"/> No
Seizures	<input type="radio"/> Yes <input type="radio"/> No	Migraines	<input type="radio"/> Yes <input type="radio"/> No
Peripheral neuropathy	<input type="radio"/> Yes <input type="radio"/> No	Strokes	<input type="radio"/> Yes <input type="radio"/> No
Fainting	<input type="radio"/> Yes <input type="radio"/> No	Seasonal eye symptoms	<input type="radio"/> Yes <input type="radio"/> No
Eye disease	<input type="radio"/> Yes <input type="radio"/> No	Light sensitivity	<input type="radio"/> Yes <input type="radio"/> No
Shortness of breath	<input type="radio"/> Yes <input type="radio"/> No	Cough	<input type="radio"/> Yes <input type="radio"/> No
Tobacco use	<input type="radio"/> Yes <input type="radio"/> No	History of asthma /COPD	<input type="radio"/> Yes <input type="radio"/> No
Angioedema	<input type="radio"/> Yes <input type="radio"/> No	Seasonal allergies	<input type="radio"/> Yes <input type="radio"/> No
Recurrent infections	<input type="radio"/> Yes <input type="radio"/> No	Anemia	<input type="radio"/> Yes <input type="radio"/> No
Easy bleeding	<input type="radio"/> Yes <input type="radio"/> No	Enlarged lymph nodes	<input type="radio"/> Yes <input type="radio"/> No
Alcohol	<input type="radio"/> Yes <input type="radio"/> No		
Recreational drug use	<input type="radio"/> Yes <input type="radio"/> No		
Occupational history of sun exposure	<input type="radio"/> Yes <input type="radio"/> No		
History of tanning bed use	<input type="radio"/> Yes <input type="radio"/> No		
Sun screen use	<input type="radio"/> Yes <input type="radio"/> No		
Use of sun protective clothing	<input type="radio"/> Yes <input type="radio"/> No		
Recreational history of sun exposure	<input type="radio"/> Yes <input type="radio"/> No		
Healing problems	<input type="radio"/> Yes <input type="radio"/> No		
Suspicious skin lesion	<input type="radio"/> Yes <input type="radio"/> No		
Travel outside US	<input type="radio"/> Yes <input type="radio"/> No		