Commerce Institute of Skin

Annette C. LaCasse, D.O.

Insurance: _____ Today's Date:_____

Patient Form

Patients Full Name: _____

Birthdate/AGE _____ / ____ **Phone Number**: _____**Cell**_____

Referred by: _____ **Address:** _____

Allergies: _____ _____

_____ _____

_____ **Email:** _____

Occupation: _____

Please mark any of the following you have had in the past or currently have:

___ Diabetes
___ High Cholesterol
___ Thyroid Disease
___ Herpes Infection
___ High Blood Pressure
___ Heart Attack
___ Angina/Chest Pain
___ Congestive Heart Failure
___ Other Heart Disease
(Specify _____)
___ Hiatal Hernia
___ Liver Disease
___ Stomach Ulcers
___ Disease of the Colon
___ Hemorrhoids
___ Tobacco Use (How much _____)
___ Alcohol Use (How much _____)
___ IV Drug Use
___ Kidney Disease
___ Bladder Problems
___ Prostate Problems

___ Asthma
___ Chronic Bronchitis
___ Emphysema
___ Allergies
___ Pneumonia
___ Other Lung Disease
___ Exposure to TB
___ Headaches
___ Stroke
___ Seizures/Epilepsy
___ Broken Bones/Accidents
___ Head Injury
___ Fainting
___ HIV Testing Results_____

___ Depression
___ Anxiety
___ Psychiatric Illness

___ Arthritis
___ Osteoporosis
___ Gout
___ Back Problems
___ Eye Problems
___ Ear Problems
___ Muscle Weakness
___ Blood Transfusions
___ Bleeding/Clotting Disorder
___ Anemia
___ Cancer (Specify_____)
___ Reaction to Local Anesthetic
___ Abnormal Skin Healing
___ Reaction to Substances Applied to skin

___ Cosmetic Surgery (What Type: _____)

Is there anything else you would like to tell us about your past or present medical history? _____

_____

Social History:

Do you live alone? Yes ___ No ___ Married: N___ Y___ Spouse's Name:_____

Of Children _____

Name and ages of Children: _____ _____

_____ _____

_____ _____

_____ _____

Hobbies/Leisure activities: _____

Employed By: _____

Emergency Contact:

Name: _____ Phone Number: _____ Relationship: _____

Patient Signature _____ Date_____