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New Rochelle, NY 10804
914-637-2663

WP HOSPITAL physician associates

Lesa Kelly, M.D.
Adult & Pediatric
Dermatology
Dermatological Surgery

Patient Demographics

Last Name _____ First Name _____ Middle Initial _____

SSN _____ Date of Birth _____ Age _____ Gender F M

Address _____ Apt. # _____ City _____ State _____ Zip _____

Home Phone _____ **Day Phone** _____

Email Address _____ **Cell Phone** _____

Race:
☐ American Indian/Alaska Native ☐ Asian ☐ White
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Decline to Answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer **Preferred Language**: _____

Marital Status: ☐ Single ☐Married ☐ Divorced ☐Widowed ☐Separated Student Status ☐FT ☐PT

Primary Care Physician Name: _____ Phone: _____

Referring Physician Name: _____Phone: _____

Emergency Contact _____/_____ Phone _____
Name Relationship

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Employer _____ Occupation _____ ☐Retired?

Employer Address _____

Primary Insurance Coverage: _____

Policy Holder Name: _____ SSN:_____ DOB:_____

Secondary Insurance Coverage: _____

Policy Holder Name: _____ SSN: _____ DOB: _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Responsible Party Signature _____ Date_____

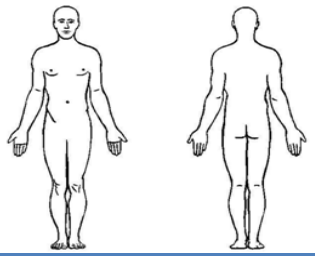
Internist/ Pediatrician Name: _____ Date:_____

Patient History Form

Name: _____ Date of Birth: _____

Reason for Visit:

Location:



Duration:

Previously Treated:

Please List All Current Medications ☐ **Not Currently Taking Any Medications**

Medication Name	Dosage	How Often Taking	Indication (Medical Reason)	Prescribing Physician

Allergies (e.g. medication, latex, egg) ☐ **No Known Allergies**

Allergen	Reaction	Allergen	Reaction

Past Medical History

Please Check all that apply : ☐ **No Medical History**

☐	Diabetes Mellitus	☐	Anxiety	**FEMALE**	
☐	Thyroid Disease	☐	Depression	☐	Polycystic Ovary Syndrome
☐	Crohn's Disease	☐	Mental Disorder	☐	Amenorrhea
☐	Ulcerative Colitis	☐	Epilepsy	☐	Pregnant Due Date:_____
☐	Inflammatory Bowel Disease	☐	Migraines		
☐	GERD	☐	Asthma	☐	**LMP**:_____
☐	Ulcers (GI)	☐	COPD	☐	Breastfeeding
☐	Hepatitis	☐	Pulmonary Embolism	**MALE**	
☐	Collagen Vascular Disease	☐	Sarcoidosis	☐	Undescended Testicle
☐	Lupus	☐	Cardiac Arrest	☐	Hypogonadism
☐	Scleroderma	☐	Heart Murmur		
☐	Rheumatoid Arthritis	☐	Hypertension		
☐	Psoriatic Arthritis	☐	High Cholesterol		
☐	Osteoarthritis	☐	Atrial Fibrillation		
☐	Anemia	☐	Artificial Heart Valve		
☐	History of Embolus	☐	Pacemaker		
☐	Cancer Treatment:	☐	Anaphylaxis		
		☐	Urticaria		
		☐	Dermatographism		

Patient Name: _____ Date of Birth: _____

Skin Cancer History

Please check all that apply : ☐ **No history of skin cancer**

☐	**Basal Cell Carcinoma** Yr Diagnosed: Location: Treatment:	☐	**Squamous Cell Carcinoma** Yr Diagnosed: Location: Treatment:	☐	**Melanoma** Yr Diagnosed: Location: Treatment:
☐	Yr Diagnosed: Location: Treatment:	☐	Yr Diagnosed: Location: Treatment:	☐	Yr Diagnosed: Location: Treatment:

Dermatology History

Please check all that apply : ☐ **No Dermatology history**

☐ Actinic keratosis	☐ Raynaud's phenomenon	☐ Keloid
☐ Dysplastic Nevi	☐ STD	☐ Eczema
☐ Anesthetic complications	☐ HIV/AIDS	☐ Psoriasis

Family History

☐ **None** ☐ **Unknown/Adopted**

☐ Asthma	☐ Squamous Cell Carcinoma	☐ Lupus
☐ Eczema	☐ Melanoma	☐ Scleroderma
☐ Psoriasis	☐ Dysplastic Nevi	
☐ Basal Cell Carcinoma	☐ Collagen Vascular Disease	

Past Surgical History

Please check all that apply : ☐ **No Surgical History**

☐	AAA Repair	☐	Hernia, inguinal	☐	Thyroidectomy, total
☐	AAA stent	☐	Hernia, umbilical	☐	Tonsillectomy
☐	Adenoidectomy	☐	Hernia, ventral	☐	TURP
☐	Aortic valve repair	☐	Knee Menisectomy	☐	Vasectomy
☐	Aortic valve replacement	☐	Knee Replacement	☐	Other:
☐	Appendectomy	☐	Laminectomy		
☐	CABG	☐	Lumbar fusion		
☐	Cartoid endarterectomy	☐	Lung removal partial		
☐	Carpal tunnel release	☐	Lymph node biopsy		
☐	Cervical discectomy	☐	Mitral valve repair		
☐	Cholecystectomy	☐	Mitral valve replacement		
☐	Coronary PTCA	☐	Pacemaker		
☐	Defibrillator	☐	Prostate Biopsy		
☐	Gastric bypass	☐	Shoulder rotator cuff		
☐	Gastric Lap Band	☐	Splenectomy		
☐	Gastric sleeve	☐	Thyroidectomy, partial		

Patient Name: _____ Date of Birth: _____

Please check all that apply : ☐ **None**

REVIEW OF SYSTEMS

CONSTITUTION		GI		INTEGUMENTARY	
☐	Activity change	☐	Abdominal distention	☐	Bruising
☐	Appetite change	☐	Abdominal pain	☐	Cold Sores
☐	Chills	☐	Anal bleeding	☐	Dry Skin
☐	Diaphoresis	☐	Blood in stool	☐	Folliculitis
☐	Fatigue	☐	Constipation	☐	Itching
☐	Fever	☐	Diarrhea	☐	Oral Lesions
☐	Unexpected weight change	☐	Nausea	☐	Pigment Change
HENT		☐	Rectal Bleeding	☐	Rash
☐	Congestion	☐	Vomiting	**SKIN**	
☐	Dental Problem			☐	Color change
☐	Drooling	**ENDOCRINE**		☐	Pallor
☐	Ear discharge	☐	Cold intolerance	☐	Rash
☐	Ear pain	☐	Heat intolerance	☐	Wound
☐	Facial swelling	☐	Polydipsia	**ALLERG/IMMUNO**	
☐	Hearing loss	☐	Polyphagia	☐	Environmental allergies
☐	Mouth sores	☐	Polyuria	☐	Food allergies
☐	Nosebleeds			☐	Immunocompromised
☐	Postnasal drip			**NEUROLOGICAL**	
☐	Rhinorrhea			☐	Dizziness
☐	Sinus pressure	**GU**		☐	Facial asymmetry
☐	Sneezing	☐	Difficulty urinating	☐	Headaches
☐	Sore throat	☐	Dysuria	☐	Light- headedness
☐	Tinnitus	☐	Enuresis	☐	Numbness
☐	Trouble swallowing	☐	Flank pain	☐	Seizures
☐	Voice change	☐	Frequency	☐	Speech difficulty
EYES		☐	Genital sore	☐	Syncope
☐	Eye discharge	☐	Hematuria	☐	Tremors
☐	Eye itching	☐	Penile discharge	☐	Weakness
☐	Eye pain	☐	Penile pain	**HEMATOLOGIC**	
☐	Eye redness	☐	Penile swelling	☐	Adenopathy
☐	Photophobia	☐	Scrotal swelling	☐	Bruises/ bleeds easily
☐	Visual disturbance	☐	Testicular pain	**PSYCHIATRIC**	
RESPIRATORY		☐	Urgency	☐	Agitation
☐	Apnea	☐	Urine decreased	☐	Behavior problem
☐	Chest tightness	**MUSC**		☐	Confusion
☐	Choking	☐	Arthralgias	☐	Decreased concentration
☐	Cough	☐	Back pain	☐	Dysphoric mood
☐	Shortness of breath	☐	Gait problem	☐	Hallucinations
☐	Stridor	☐	Joint swelling	☐	Hyperactive
☐	Wheezing	☐	Myalgias	☐	Nervous/anxious
CARDIOVASCULAR		☐	Neck pain	☐	Self-injury
☐	Chest Pain	☐	Neck stiffness	☐	Sleep disturbance
☐	Leg swelling			☐	Suicidal ideas
☐	Palpitations				

Social History

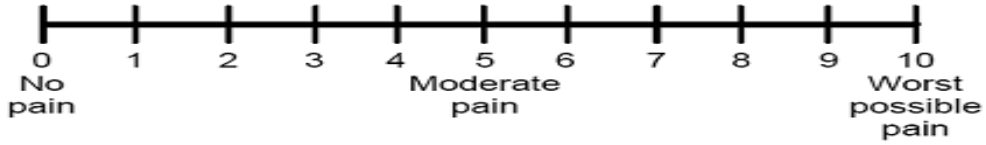
Smoking Tobacco Use History (all patients age 13 and older):		If there is a history of tobacco use:
☐ Never Smoker	☐ Current Every Day Smoker	Years Used: _____
☐ Former Smoker	☐ Current Some Day Smoker	Usage Per Day:_____
☐ Unknown if Ever Smoker	☐ Smoker Current Status Unknown	Age Stopped:_____

Do You Consume Alcohol? ☐ No ☐ Yes ☐Former Frequency: _____ Amount: _____

Do You Consume Caffeine? ☐ No ☐ Yes Type: _____ Caffeine per day: _____

Pain Assessment

Please indicate (circle) your current pain scale in relation to your dermatological condition:



Falls/Hospitalization

Have you had any falls in the last year? ☐ Yes ☐ No If Yes, please state the number of falls: _____	Did the fall(s) result in injury? ☐ Yes ☐ No

Have you been hospitalized in the last 30 days? ☐ Yes ☐ No, If Yes when were you discharged? _____

Advance Directive- Health Care Proxy

Do you have any Advance Directive documents? ☐ Yes ☐ No ☐ Patient under 18
(e.g.. living will, power of attorney, do not resuscitate (DNR) orders

Patient Signature: _____ Date: _____

Patient Representative Signature:_____ Relationship: _____