Dermatology Specialists of Monmouth County
Orsini, Gilson, and Miller M.D.
Loren Franco, M.D. and Michael Goldfarb, M.D.

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MEDICAL INFORMATION

Name: ______________________

Date of Birth: ______________________ Preferred Phone #: ______________________

Email Address: ______________________

Do you have any Allergies to medication? ◯ Yes ◯ No If yes please list:

Have you ever had a reaction to lidocaine/ novacaine /epinephrine? ◯ Yes ◯ No

Have you ever had a reaction to latex? ◯ Yes ◯ No

Have reaction to adhesive/bandages? ◯ Yes ◯ No

Do you have hypertension? ◯ Yes ◯ No

Are you diabetic? ◯ Yes ◯ No

Do you have joint replacement? ◯ Yes ◯ No

Do you take "blood thinners"? Including Aspirin? ◯ Yes ◯ No

If so, which ones: ______________________

Have you ever had skin cancer? ◯ Yes ◯ No

If yes please describe type and date: ______________________

Do you have a family history of Melanoma? ◯ Yes ◯ No

List family member: ______________________

Please check:

☐ Are you immunosuppressed?

☐ Have Hepatitis?

☐ Have HIV?

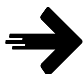
Have you been fully vaccinated for COVID-19? ◯ Yes ◯ No

Who referred you to our practice? ______________________

Do you have any other major health problems? Past or Present?

List all medication (Name, Dose, Frequency)

1 ______________________ 2 ______________________
3 ______________________ 4 ______________________
5 ______________________ 6 ______________________
7 ______________________ 8 ______________________
9 ______________________ 10 ______________________
11 ______________________ 12 ______________________
13 ______________________ 14 ______________________
15 ______________________ 16 ______________________



PATIENT'S SIGNATURE

Date