Fred S. Hirsh, M.D., Inc.
Alex T. Hirsh, M.D. Laura A. Kwasniak, M.D.
Dermatology and Dermatological Surgery

Thank you for taking the first step in preparing to create your electronic medical record. After you have printed out the Patient Information Form please complete the form and fax the finished pages to:

(440) 460-2885

Or mail the form to:

Fred S. Hirsh, M.D., Inc.
6551 Wilson Mills Rd.
Mayfield Village, Ohio 44143
Attention: Patient Forms

Alternatively, you may bring the forms with you to your appointment but this may require a few extra minutes during your visit with us.

Thank you,

Dr. Alex Hirsh and Dr. Laura Kwasniak

Patient Name:_____
Date:_____

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Patient Information Form

Please Fax completed form to:
440-460-2885

Patient Name _____ □ Male □ Female
(Please Print) First Middle Last

Date of birth: _____ Age: _____ Patient Social Security Number _____

Home Address: _____
Street Apartment number

_____
City State Zip code

Seasonal Address: _____
(From: _____ to _____) Street Apartment number

_____
City State Zip code

Preferred phone to be contacted:

Preferred Phone: (_____)_____ □ Single □ Married □ Divorced □ Widow

Secondary Phone: (_____)_____

Work Phone: (_____)_____ Email: _____

Is it OK to leave a detailed message? □ Yes □ No Is it OK to contact you via email? □ Yes □ No

Insurance Policy Holder's information: (billing information should be sent to: □ patient address □ insurance policy holder address)
Name: _____
First Middle Last

Date of birth: _____ ID Number/Social Security Number _____

Address: _____
□ Same as above Street Apartment number

_____
City State Zip code

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address (or intersection): _____

Pharmacy Zip Code: _____

Pharmacy Phone: (_____)_____

Mail Away Pharmacy Name: _____

(Please fill out back)

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Medical History:

Select any of the following conditions you currently have:

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial Fibrillation
- □ BPH
- □ Bone Marrow Transplant
- □ Breast Cancer
- □ Colon Cancer
- □ COPD
- □ Coronary Artery Disease
- □ Depression
- □ Diabetes
- □ End Stage Renal Disease
- □ GERD
- □ Other _____
- □ Hearing Loss
- □ Hepatitis
- □ Hypertension
- □ HIV/AIDS
- □ High Cholesterol
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Prostate Cancer
- □ Radiation Treatment
- □ Seizures
- □ Stroke

Have you had any of the following skin conditions:

- □ Acne
- □ Actinic Keratoses
- □ Asthma
- □ Basal Cell Cancer
- □ Blistering Sunburns
- □ Dry Skin
- □ Eczema
- □ Other _____
- □ Flaking/itchy scalp
- □ Hay fever/allergies
- □ Melanoma
- □ Poison Ivy
- □ Abnormal Moles
- □ Psoriasis
- □ Squamous cell cancer

Do you wear sunscreen? □ Yes □ No SPF:_____
Do you have a family history of Melanoma? ? □ Yes □ No
If yes, which relative? _____

Please list your current medications (including any regular over the counter medications/vitamins):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

Have you had any surgeries on the following organs?

- □ Appendix (Appendectomy)
- □ Bladder (Cystectomy)
- □ Breast: Mastectomy
  - □ Right Breast
  - □ Left Breast
  - □ Both Breasts
- □ Breast: Lumpectomy
  - □ Right Breast
  - □ Left Breast
  - □ Both Breasts
- □ Breast: Breast Biopsy
- □ Breast: Breast Reduction
- □ Breast: Breast Implants
- □ Colon
  - □ Cancer Resection
  - □ Divertiulitis
  - □ Inflammatory Bowel disease resection
- □ Gallbladder: Cholecystectomy
- □ Heart:
  - □ Coronary Artery Bypass Surgery
  - □ PTCA
  - □ Mechanical Valve
  - □ Biological Valve
  - □ Heart Transplant
- □ Joint Replacement
  - □ Knee (Right)
  - □ Knee (Left)
  - □ Knee (Both)
  - □ Hip (Right)
  - □ Hip (Left)
  - □ Hip (Both)
- □ Kidney Biopsy
- □ Kidney Nephrectomy
- □ Kidney Stone Removal
- □ Kidney Transplant
- □ Ovary removal:
  - □ Endometriosis
  - □ Ovarian Cyst
  - □ Ovarian Cancer
- □ Prostate:
  - □ Prostate Cancer
  - □ Prostate Biopsy
  - □ TURP
- □ Skin biopsy
- □ Basal Cell Carcinoma
- □ Squamous Cell Carcinoma
- □ Melanoma
- □ Splenectomy
- □ Testicles (orchidectomy)
- □ Hysterectomy (fibroids)
- □ Hysterectomy: Uterine Cancer
- □ _____
  _____

Do you have any **allergies** to medications?
□ No □ Yes (Please list and include the allergic reaction that occurs when taking that medication):

1. _____
2. _____
3. _____
4. _____
5. _____

Do you smoke? □ No □ In the past (year quit _____)
□ Yes (□ occasionally □ daily (packs per day_____)

Alcohol Use

- □ None
- □ Less than 1 drink per day
- □ 1-2 drinks per day
- □ 3 or more drinks per day

Patient Name:_____ Date:_____