

Fred S. Hirsh, M.D., Inc.  
Fred S. Hirsh, M.D.      Alex T. Hirsh, 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 and Fred Hirsh and Staff

Patient Name: \_\_\_\_\_  
Date: \_\_\_\_\_

**Patient Information Form**

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

Home Phone: (\_\_\_\_\_) \_\_\_\_\_  Single  Married  Divorced  Widow

Business Phone: (\_\_\_\_\_) \_\_\_\_\_

Mobile Phone: (\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Preferred Phone:  Home  Work  Mobile Is it OK to contact you via email?  Yes  No  
Is it OK to leave a detailed message?  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: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Date: \_\_\_\_\_

**Medical History:**

Select any of the following conditions you currently have:

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

Have you had any of the following skin conditions:

- |  |   |
|--|---|
| <input type="checkbox"/> Acne                | <input type="checkbox"/> Flaking/itchy scalp  |
| <input type="checkbox"/> Actinic Keratoses   | <input type="checkbox"/> Hay fever/allergies  |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Melanoma             |
| <input type="checkbox"/> Basal Cell Cancer   | <input type="checkbox"/> Poison Ivy           |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Abnormal Moles       |
| <input type="checkbox"/> Dry Skin            | <input type="checkbox"/> Psoriasis            |
| <input type="checkbox"/> Eczema              | <input type="checkbox"/> Squamous cell cancer |
| <input type="checkbox"/> Other _____         |   |

Do you use 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?

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

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 \_\_\_\_\_))

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_