Center for Excellence in Dermatology ***New Patient Medical History Form***

Date: _____/_____/_____ ***Name:*** _____ ***DOB:*** _____

Best Contact Number: _____ ***Ok to leave a message:*** *Y / N*

Referring Provider: *(Name / Phone)* _____

Preferred Pharmacy: *(Name / Phone)* _____

Weight: _____ ***Height:*** _____

Reason for Today's Visit: _____

Symptoms of your current skin condition (please circle): Bleeding Itching Painful Growing Changing

Duration of Skin Condition: _____

Have you tried any Medications for this current Condition? Y / N

If yes, please list: _____

Personal Past Medical History of Current Diseases*:*

Skin Cancer	*Y*	*N*	*HIV/ Aids*	*Y*	*N*
Actinic Keratosis	*Y*	*N*	*Hepatitis C/ Liver Disease*	*Y*	*N*
Melanoma	*Y*	*N*	*Thyroid Disorders*	*Y*	*N*
Cancers	*Y*	*N*	*Diabetes*	*Y*	*N*
Psoriasis	*Y*	*N*	*Eczema*	*Y*	*N*
Seasonal Allergies / Hay Fever	*Y*	*N*	*High Blood Pressure*	*Y*	*N*
Keloids	*Y*	*N*	*Pacemaker / Defibrillator*	*Y*	*N*
Autoimmune Disease	*Y*	*N*	*Arthritis / Artificial Joints*	*Y*	*N*

*If you answered **YES** to any of the above, Please Explain:* _____
Other Major Medical illness / Surgeries: _____

Family History: *If any blood relative has any condition listed below, check and specify which blood relative.*

Allergies/ Hay Fever ( ) _____ *Severe Acne ( )* _____ *Other Cancer ( )*_____

*Eczema ( )*_____ *Psoriasis ( )* _____ *Heart Disease ( )* _____

*Asthma ( )*_____ *Diabetes ( )*_____ *High Blood Pressure ( )*_____

*Hives ( )*_____ *Skin Cancer ( )*_____ *Autoimmune Disease ( )*_____

Allergies *(Medication, Latex, Food):*

Review of Systems*: Are you having any of these symptoms today? ( ) Yes ( ) No, If **YES**, please circle: Fever, Chills, Nausea, Vomiting, Diarrhea, Constipation, Chest Pain, Shortness of Breath, Cough, Headaches, Numbness, Joint Pain, Vision Changes, Unintended Weight Loss, Anxiety, Depression, Easy Bruising / Bleeding*

Alcohol Use*: (18 Yrs. And older)* How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women? #_____

Tobacco Use: Do you smoke, Vape or Use Tabacco products? **Yes** Or **No**

Current Medication:	***Dose:***	***Frequency:***