

## Dermatology New Patient History

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Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Physician \_\_\_\_\_

Reason for Visit \_\_\_\_\_

Duration of Problem \_\_\_\_\_

Treatments Used \_\_\_\_\_

**Do you have a history of any of the following (check yes or no):**

	Y	N		Y	N		Y	N
High Blood Pressure			Diabetes			Melanoma		
Heart Attack			Asthma			Other Skin Cancer		
Heart Failure			Hayfever			Bleeding Disorder		
High Cholesterol			Thyroid Disease			Problems with Scarring		
Liver Disease			Hepatitis			Do You Smoke		
Kidney Disease			HIV			Do You Drink Alcohol		

Any Other Medical Problems \_\_\_\_\_

Operations/Surgeries \_\_\_\_\_

Medicines You Are Taking \_\_\_\_\_

Drug Allergies \_\_\_\_\_

Family History of Medical Problems \_\_\_\_\_

**Are you currently having any of the following symptoms (check yes or no):**

	Y	N		Y	N		Y	N
Fever			Frequent Urination			Blurred Vision		
Headache			Abdominal Pain			Joint Pain		
Nausea			Chest Pain			Difficulty Breathing		
Dizziness			Poor Appetite			Coughing		
Tired/Sluggish			Weight Loss			Swelling		

Any Other Current Symptoms \_\_\_\_\_

***Please Note:*** The American Cancer Society recommends a complete, head to toe examination of your skin by a physician, on a periodic basis, to screen for melanoma and other skin cancers. Early diagnosis of melanoma can be life saving. Please notify our staff if you wish to make an appointment for a complete skin examination.

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_