New Patient Medical History

Date of Appointment: ____/____/____

Name: (Last)_____ (First)_____

Date of Birth: ____/____/____

DATE: ____/____/____

I was referred here today by Dr._____

My immediate family member treated here: _____

_____

1. Drug Allergies: ____ NO ☐ YES ☐ LIST: _____

2. Names of current medications: (include herbal medications, over the counter products and products used on the skin)

_____ _____ _____

_____ _____ _____

_____ _____ _____

3. Past Medical History: Check diseases that you have or had

NONE	☐	Cancer (skin)		**Hepatitis**	☐	**4. Past Surgical History** (Check past operations)	
Acne, scarring	☐	A. BCC	☐	High Blood Pressure	☐	Appendectomy	☐
Allergies (seasonal)	☐	B. SCC	☐	High Cholesterol	☐	C-Section (s)	☐
Anxiety	☐	C. Melanoma	☐	**HIV**	☐	Gallbladder	☐
Arthritis	☐	Celiac Disease	☐	Hyperthyroidism	☐	Heart Bypass Surgery	☐
Arthritis, Osteo	☐	Depression	☐	Hypothyroidism	☐	Hernia Repair	☐
Arthritis, Rheumatoid	☐	Diabetes	☐	Lung Disease	☐	Hip Replacement	☐
Asthma	☐	Diet Counseling	☐	Lupus	☐	Hysterectomy	☐
Cancer (non-skin)	☐	Eczema	☐	Psoriasis	☐	Knee Replacement	☐
A. Type:_____		Exercise Counseling	☐	Smoking Cessation Class	☐	Skin Cancer Surgery	☐
		Heart Disease	☐	Other:_____	☐	Tonsillectomy	☐
						Other:_____	

5. Review of Systems: Have you **recently experienced** any of the following? (If yes, check the box and explain)

General Health			**GU-Kidney**		
A. Fever	☐	_____	A. Frequent Urination	☐	_____
B. Weight gain	☐	_____	B. Burning with urination	☐	_____
C. Weight loss	☐	_____	C. Bloody Urine	☐	_____
D. Fatigue	☐	_____	**Arthritis/Muscles/Joints**		
Eyes			A. Joint Pain	☐	_____
A. Dry eyes	☐	_____	B. Muscle Pain	☐	_____
B. Gritty sensation	☐	_____	C. Muscle weakness	☐	_____
Ear, Nose, Throat			**Psychological Disorder**		
A. Dry Mouth	☐	_____	A. Stress	☐	_____
B. Hearing loss	☐	_____	B. Anxiety/panic attacks	☐	_____
Cardiovascular			C. Depression	☐	_____
A. Swelling of feet/legs	☐	_____	**Endocrine Disease**		
B. Calf pain	☐	_____	A. Increased thirst	☐	_____
Stomach-Bowel			B. Heat/Cold Intolerance	☐	_____
A. Bloody stools	☐	_____	C. Change in hair or nails	☐	_____
B. Diarrhea	☐	_____	**Allergy/Immunology**		
C. Gas/bloating	☐	_____	A. Itchy, watery eyes	☐	_____
D. Nausea	☐	_____	B. Runny nose, wheezing	☐	_____

6. Family Medical History: (check answers)

	Father	Mother	Brother	Sister
Acne, scarring	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Cancer (not skin cancer)	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Hair loss	☐	☐	☐	☐
Hay fever/Allergies	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Lung disease	☐	☐	☐	☐
Lupus	☐	☐	☐	☐
Melanoma	☐	☐	☐	☐
Other Skin Cancer	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐
Thyroid disorder	☐	☐	☐	☐

7. Females Only: (check or write answers)

Are you pregnant? Yes ☐ No ☐

Breastfeeding? Yes ☐ No ☐

Are you Menopausal? Yes ☐ No ☐

Are your periods regular? Yes ☐ No ☐

If no explain:_____

Birth Control Method:_____

8. Social History (circle, check or write an answer)

Marital Status: S M D W

Occupation:_____

Do you smoke? Yes ☐ No ☐

If yes, how many packs per day _____

9. Sun Exposure: (circle answers)

Amount: (minimal) (moderate) (excessive) (work outside)

History of Sunburn: (none) (childhood) (teens) (last yr)

Hx of Blistering: (I have blistered) (I have not blistered)

Sunscreen use: (don't use) (SPF 8-15) (SPF 15-30) (30+)