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Dermatology & Dermatologic Surgery

New Patient Questionnaire

Name: _____ Patient Date of Birth: _____

Name & Relation of person completing Form (if different from above):_____

Who is your primary care provider (first and last name)? _____

Please list any other dermatologist you have seen: _____

Please list any other health care providers you see and what condition you see them for: _____

_____

_____

Pharmacy: _____ Phone number: _____City or zip code: _____
Do you use a mail order pharmacy? ❑ Yes ❑ No 90 day supply (when possible): ❑ Yes ❑ No
If so which one do you use? _____

List all Prescription Medication (if you have a list, we can photograph for your chart): [Use last page if you need more room]
_____

_____

_____

List all Over the Counter Medications: _____

_____

List allergies to medications (including reaction):_____

_____

Skin Cancer Risk Factors – Please mark all that apply:

- ☐ Immunosupressive medications (Please circle the medication): Enbrel, Humira, Otezla, Stelara Plaquenil, Predisone Chemotherapy
- ☐ Organ or Bone Marrow transplantation
- ☐ Radiation Treatment: _____
- ☐ HIV infection/treatment
- ☐ Lymphoma or Leukemia (cancer of blood cells or bone marrow)
- ☐ Blistering Sun Burn (s)
- ☐ Tanning Salon (past or current)

Medical Alerts (things we need to know):

- ☐ Allergy to Adhesive
- ☐ Allergy to lidocaine (or other numbing meds)
- ☐ Allergy to antibiotic ointments
- ☐ Artificial Heart Valve
- ☐ Artificial Joints (when:_____)
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Blood thinning medication
- ☐ Pregnancy or planning a pregnancy
- ☐ Breast feeding

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Past Personal History, (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis, What type? _____
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH (enlarged prostate)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Other Cancer: _____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Lupus (LSE) or other rheumatologic/connective tissue disease Specify: _____
- ☐ Depression
- ☐ Diabetes (Type I or Type II)
- ☐ End Stage Renal Disease
- ☐ GERD (acid reflux)
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Heart Disease, Specify: _____
- ☐ High Blood pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Thyroid Disease, What type? _____
- ☐ Leukemia
- ☐ Lung Disease, What Type?_____
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Blood Clots (in legs or lungs)
- ☐ Dementia/Alzheimer's Disease

Past Surgical History, (please check all that apply)

Please list all surgeries with dates:

_____

_____

Skin Disease History: (please check all the apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Rosacea
- ☐ Herpes
- ☐ MRSA
- ☐ Other: _____

Do you wear Sunscreen? ❑ Yes ❑ No If yes, what SPF? _____

Do you have a family history of skin cancer? ❑ Yes ❑ No

If yes, please specify type and which relative(s)?

_____

Social History: (please check all that apply)

Cigarette Smoking:

- ☐ Currently Smokes
- ☐ Never smoked
- ☐ Former Smoker

Alcohol Use:

- ☐ None
- ☐ less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Currently sexually active? ❑ Yes ❑ No

Name: _____ Patient Date of Birth: _____

What soap do you use to wash your face? _____ Body? _____
What moisturizer do you use? _____
Sports/Hobbies? _____
Occupation? _____
Student? (Where? What Grade/Year?) _____

Review of Systems: Are you currently experiencing the following?

Constitutional:
- ☐ Fever
- ☐ Unexplained weight loss or gain
- ☐ Fatigue
- ☐ Night sweats

Skin:
- ☐ Rashes or color changes
- ☐ Itching or dryness
- ☐ Hair or nail changes
- ☐ Problems with healing
- ☐ Problems with scarring (keloid formation)

Eyes:
- ☐ Eye pain or soreness
- ☐ Dry or itchy eyes
- ☐ Blurry vision

Ear, Nose, Mouth, Throat
- ☐ Hearing difficulty
- ☐ Ringing or dizziness
- ☐ Sinus congestions
- ☐ Runny nose/postnasal drip
- ☐ Nose bleed
- ☐ Dryness or hoarseness
- ☐ Mouth sores
- ☐ Sore throat

Cardiovascular
- ☐ Chest pain or palpitations

Hematological-Lymphaties-Immunology
- ☐ Easy bruising
- ☐ Problems with bleeding
- ☐ Swollen lymph nodes

Endocrine:
- ☐ Heat or cold intolerance
- ☐ Excessive thirst or hunger

Gastrointestinal:
- ☐ Nausea or vomiting
- ☐ Heartburn
- ☐ Ulcers
- ☐ Abdominal pain

Musculoskeletal
- ☐ Joint pain, swelling
- ☐ Muscle pain or cramps
- ☐ Neck stiffness

Neurological
- ☐ Headache
- ☐ Numbness or tingling
- ☐ Seizures

Genito-Urinary
- ☐ Blood urine

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Asthma

Psychiatric
- ☐ Anxiety
- ☐ Depression

Other symptoms not listed:
_____
_____

Family History: (only first-degree relatives, parents, siblings, children)

Do any of your first-degree relatives have? (Check all that apply)

- ☐ Hayfever
- ☐ Asthma
- ☐ Acne, eczema, psoriasis
- ☐ Thyroid disease Specify: _____
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Lupus (SLE)
- ☐ Rheumatoid Arthritis
- ☐ Cancer, Specify: _____

_____ _____

Patient Signature Date