I.A. Tangoren M.D., P.L.L.C.
New Patient Questionnaire

Name: _____ Patient Date of Birth: _____

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

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

Skin issues that you would like addressed today: _____

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 (or provide list to provider): [Use back of last page if you need more room]

_____

_____

List all over the counter medications: _____

List allergies to medications (including reaction):_____

Occupation or student status**:** _____

Skin Cancer Risk Factors (please check all that apply):

- ☐ Immunosuppressive medications (Please circle the medication): Enbrel, Humira, Otezla, Stelara, Prednisone, Chemotherapy, Cosentyx, Taltz, Dupixent, Tremfya
- ☐ Blistering Sun Burn (s)
- ☐ Organ or bone marrow transplantation
- ☐ Radiation Treatment: _____
- ☐ HIV infection/treatment
- ☐ Lymphoma or Leukemia (cancer of blood cells or bone marrow)
- ☐ Tanning Salon (past or current)

Medical Alerts (please check all that apply

- ☐ 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
- ☐ HIV/AIDS

Past Medical History (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis, What type? _____
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Benign prostatic hyperplasia (enlarged prostate)
- ☐ Cerebrovascular accident (stroke)
- ☐ COPD
- ☐ Coronary arteriosclerosis
- ☐ Depression
- ☐ Diabetes (Type I or Type II)
- ☐ Disease caused by 2019-nCoV
- ☐ High Blood pressure
- ☐ End Stage Renal Disease
- ☐ Epilepsy or Seizures
- ☐ GERD (acid reflux)
- ☐ Hypertension
- ☐ Hearing Loss
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Thyroid Disease: circle one hyper or hypo
- ☐ Inflammatory disease of liver
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Prostate Cancer
- ☐ Other Cancer:_____
- ☐ Radiation therapy treatment management
- ☐ Transplantation of bone marrow
- ☐ Radiation Treatment
- ☐ Blood Clots (in legs or lungs)
- ☐ Dementia/Alzheimer's Disease
- ☐ Lupus (LSE) or other rheumatologic/connective tissue disease Specify: _____

Past Surgical History

Please list all surgeries with dates:

_____

_____

Skin Disease History (please check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asteatosis Cutis
- ☐ Basal Cell Skin Cancer
- ☐ Poison Ivy
- ☐ Dysplastic Nevus
- ☐ Eczema
- ☐ Asthma
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Puritus of scalp (itchy scalp)
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Rosacea
- ☐ Herpes
- ☐ MRSA
- ☐ Other: _____

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

Do you tan in a tanning salon ❑ Yes ❑ No If yes, how often? _____

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

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

_____

Social History (please check all that apply)

Cigarette Smoking:

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

Alcohol and Drug Use:

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

Social History Cont.

Currently sexually active? ❑ Yes ❑ No

What soap do you use to wash your face? _____ Body? _____

What moisturizer do you use? _____

Sports/Hobbies? _____

Vaccination History

Have you received any of the following vaccines (check all that apply)?

☐ Flu (this year) ☐ Pneumonia ☐ Shingles

Have you received a COVID-19 vaccine? Yes No Brand: Pfizer Moderna J&J
Dose 1 (month/year):_____ Dose 2 (month/Year): _____ Booster:_____

Review of Systems Are you currently experiencing the following?

Constitutional
- ☐ Fever or chills
- ☐ 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

Psychiatric
- ☐ Anxiety
- ☐ Depression

Other symptoms not listed:

_____

Ear, Nose, Mouth, Throat
- ☐ Hearing difficulty
- ☐ Ringing in ears
- ☐ 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 aches
- ☐ Muscle pain or cramps
- ☐ Neck stiffness

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

Genito-Urinary
- ☐ Blood in urine

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

Family History

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

- ☐ Hay fever
- ☐ Asthma
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Thyroid disease specify: _____
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Lupus (SLE)
- ☐ Rheumatoid Arthritis
- ☐ Cancer, Specify: _____

_____ _____

Patient/Parent Signature Date