



DERMATOLOGY & SKIN SURGERY

2102 E. Inwood South Bend, IN 46614

Cynthia Mayfield, M.D. Todd Rozycki, M.D. Duane Wampler, PA April Scott, NP

New Patient Form

Please complete the form below and bring to your visit.

Appointment Date: ____/____/____

Patient Name: _____

Date of Birth: ____/____/____

Social Security # ____ - ____ - ____

Age: ____ Gender: M F

Home Phone: (____) ____ - ____

Cell Phone: (____) ____ - ____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Marital Status: Married Single Divorced Legally Separated Life Partner Widowed

HEALTHCARE TEAM

Referring Provider: _____ Primary Care Provider: _____

REASON FOR TODAY'S VISIT

Reason for Visit: _____

When the symptoms began (approximate): _____

Location: Arms Back Legs Head/neck Chest/abdomen Genitals

Symptoms: Itching Bleeding Pain Other: _____

Severity: Mild Moderate Severe

What other signs and symptoms are you experiencing? *Check all that apply:*

Bleeding Cracking Crusting Dry Skin Itching Oozing Pain Rash Other: _____

Have you seen any other physicians about this problem? No Yes, whom? _____

Have you had any previous treatment for your current condition? No Yes, please list: _____

What have you used that makes it better/worse? (Medicines or over-the-counter products): _____

ALLERGIES TO MEDICATIONS

No Known Allergies Yes, list all allergies and/or intolerances to medications & indicate reaction

Medication Allergy

Reaction(s)

_____	<input type="checkbox"/> Rash	<input type="checkbox"/> Nausea	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other: _____
_____	<input type="checkbox"/> Rash	<input type="checkbox"/> Nausea	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other: _____
_____	<input type="checkbox"/> Rash	<input type="checkbox"/> Nausea	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other: _____

MEDICATIONS/VITAMINS/SUPPLEMENTS

Not taking any medications Taking medications, *list all medications, vitamins & supplements including dose*

Medication	Dose (strength & quantity)	Prescribing Doctor
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

Continue on back page if needed....

REVIEW OF SYSTESM

Do you currently suffer from any of the following problems? Check no or yes.

Constitutional		Neurological/Psychiatric		Genitourinary		Metabolic/Endocrine		
No	Yes	No	Yes	No	Yes	No	Yes	
	Fatigue or tired		Depressed mood		Change in bladder		Cold intolerance	
	Fever		Dizziness		Gastrointestinal		Heat intolerance	
	Weight gain		Headache					Hair loss
	Weight loss		Paresthesia	No	Yes		Musculoskeletal	
	Increased energy		Stress		Change in bowl habits	No		Yes
	Decreased energy				Constipation			
	Integumentary		HEENT		Diarrhea		Bone pain	
					Nausea		Joint aches/ pain	
No	Yes	No	Yes		Reproductive		Hematologic	
	Bruising		Nose bleeds	No	Yes	--- Women Only ---	No	Yes
	Chapped lips		Visual changes		Abnormal menses		Easy bleeding	
	Itching/pruritus		Stomatitis (thrush)		Yeast infections		Easy bruising	
	Photosensitivity		Cardiovascular		Nursing			
	Pigment changes					Currently pregnant		
	Rash	No	Yes					
	Scarring tendency		Chest pain					
	Thinning hair							
	Skin changes (Discoloration)							

MEDICAL HISTORY

Place a Check in the box next to the following conditions you have been diagnosed with:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes Type ____ | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Bone Marrow Transplant |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Thick Scars | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Skin Cancers – Specify: _____ | | | |
| <input type="checkbox"/> Skin Cancers - Specify: _____ | | | |

FAMILY HISTORY

Circle the letter that represents the family member: Mother (M), Father (F), Sister (S) and Brother (B)

Adopted

Father: Alive & Well Deceased, Cause of Death: _____ Age: _____

Mother: Alive & Well Deceased, Cause of Death: _____ Age: _____

Abnormal Moles	M F S B	Dermatitis	M F S B	Hypertension	M F S B
Acne	M F S B	Depression	M F S B	Malignant Melanoma	M F S B
Allergies	M F S B	Diabetes type: ____	M F S B	Psoriasis	M F S B
Asthma	M F S B	Eczema	M F S B	Rosacea	M F S B
Basal Cell Carcinoma	M F S B	Hepatitis	M F S B	Squamous Cell Carcinoma	M F S B
Cancer: _____	M F S B	Hyperlipidemia	M F S B	Other: _____	M F S B

SOCIAL HISTORY

Tobacco Do you use tobacco? No/Never Yes Former - How long ago? _____ Age Quit: _____
 Type/Status: Cigarette Cigar Pipe Chew Snuff Vape Other: _____
 How many packs per day? _____ How many years? _____

Caffeine Do you drink caffeinated beverages No Yes, what type: _____ Cups per day: _____

Alcohol Do you drink alcohol? No Yes

Tanning Do you Tan: No Yes, how often: _____ Tanning bed Outside
 Do you use sunscreen? No Yes

INSURANCE NOTICE:

Medicare or your insurance may only pay for services determined to be 'reasonable and necessary' (as defined in section 1862 of the Medicare Law). If Medicare or your insurance company determines that a particular service is not 'reasonable and necessary' under their program standards, Medicare or your insurance company may deny payment for that service.

Depending on your particular insurance, you may need to have a written referral from your physician. If this is true of your insurance, PLEASE BE ADVISED that the doctors are limited to performing or treating the specific services outlined on the referral written by your primary care physician. You should also be aware that some insurance plans require that treatment procedures be done on a separate day following the evaluation of the problem. I have read and understand the Insurance Notice and do accept responsibility for payment should my insurance at any time deny payment.

Patient or responsible party: _____ Date: ____/____/____
 (Signature)

Relationship to Patient: Self Parent Guardian Other: _____