DERMATOLOGY & SKIN SURGERY

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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)
	☐ Rash ☐ Nausea ☐ Unknown ☐ Other: ____________________
	☐ Rash ☐ Nausea ☐ Unknown ☐ Other: ____________________
	☐ Rash ☐ Nausea ☐ Unknown ☐ 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

No	Yes	
		Fatigue or tired
		Fever
		Weight gain
		Weight loss
		Increased energy
		Decreased energy

Neurological/Psychiatric

No	Yes	
		Depressed mood
		Dizziness
		Headache
		Paresthesia
		Stress

Genitourinary

No	Yes	
		Change in bladder

Metabolic/Endocrine

No	Yes	
		Cold intolerance
		Heat intolerance
		Hair loss

Gastrointestinal

No	Yes	
		Change in bowel habits
		Constipation
		Diarrhea
		Nausea

Musculoskeletal

No	Yes	
		Bone pain
		Joint aches/ pain

Integumentary

No	Yes	
		Bruising
		Chapped lips
		Itching/pruritus
		Photosensitivity
		Pigment changes
		Rash
		Scarring tendency
		Thinning hair
		Skin changes (Discoloration)

HEENT

No	Yes	
		Nose bleeds
		Visual changes
		Stomatitis (thrush)

Cardiovascular

No	Yes	
		Chest pain

Reproductive

No	Yes	*--- Women Only ---*
		Abnormal menses
		Yeast infections
		Nursing
		Currently pregnant

Hematologic

No	Yes	
		Easy bleeding
		Easy bruising

MEDICAL HISTORY

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

☐ Anemia	☐ Diabetes Type ___	☐ Hyperlipidemia	☐ Lupus
☐ Anxiety	☐ Glaucoma	☐ Hypertension	☐ Bone Marrow Transplant
☐ Blood Clots	☐ HIV/AIDS	☐ Kidney Disease	☐ Thyroid Disorder
☐ Depression	☐ Hepatitis C	☐ Liver Disease	☐ Tuberculosis (TB)
☐ Thick Scars	☐ Heart Disease	☐ Bleeding Problems	☐ Stomach Ulcers

☐ Skin Cancers – Specify: ____

☐ 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 may 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: ______________________________