Adult New Patient History Form

Print your name: ____________________________
Print date of birth: _________________________
Medical Record Number: ____________________ (if known)

PRIMARY CARE PHYSICIAN:

Physician Name: ______________________________________________________
Physician Address: ____________________________________________________
City: ___________________ State: ___________________ Zip: _________________
Telephone Number ____________________

Did a physician refer you to the Dermatology Service?  
☐ No  ☐ Yes  ☐ Same as above

Physician Name: ______________________________________________________
Physician Address: ____________________________________________________
City: ___________________ State: ___________________ Zip: _________________
Telephone Number ____________________

I authorize Dermatology to leave messages on my (please check off):

☐ Home Phone (________)
☐ Day/Work Phone (________)
☐ Cell Phone (________)

PRESENT PROBLEM(S):

What is the purpose of your visit today? _______________________________________

PAST HISTORY:

Do you have any medical problems? Please place a ✓ check mark and complete.

Diabetes ☐  Asthma ☐  Liver Disease ☐  Hay Fever ☐  High Blood Pressure ☐

Cancer ☐  (Specify type) ___________________  Other ___________________

Do you have a pacemaker?  ☐ NO  ☐ YES
Do you have an artificial joint?  ☐ NO  ☐ YES
Do you have an artificial heart valve?  ☐ NO  ☐ YES
Do you have to take antibiotics before you go to the dentist?  ☐ NO  ☐ YES  Why?
Have you used tanning beds?  ☐ NO  ☐ YES

MEDICATIONS: Do you take any prescription or over-the-counter medications regularly? Please list:

(1) __________ (2) __________ (3) __________
(4) __________ (5) __________ (6) __________

Are you allergic to any medications?  ☐ NO  ☐ YES  If yes, please list: ________________________

Do you take blood thinners?  ☐ NO  ☐ YES  If yes, please list: ________________________
Have you taken any aspirin in the last 48 hours?  ☐ NO  ☐ YES

Please turn over and complete side 2

Revised 2/6/2015
### Personal History

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>Melanoma skin cancer</td>
<td></td>
<td></td>
</tr>
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### Family History

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### Social History

**Occupation:** What kind of work do you do? ________________

**Alcohol:** Do you drink alcohol on a regular basis? [ ] Yes [ ] No

**Tobacco:** Please provide us with your current smoking status:

[ ] Never smoker  [ ] Current every day smoker  [ ] Current some day smoker  [ ] Former smoker

### Review of Systems

**GENERAL HEALTH**  [ ] NO  [ ] YES

**EYES**  [ ] NO  [ ] YES

**EARS/NOSE/MOUTH/THROAT**  [ ] NO  [ ] YES

**HEART**  [ ] NO  [ ] YES

**LIVER**  [ ] NO  [ ] YES

**LUNGS**  [ ] NO  [ ] YES

**STOMACH/BOWELS**  [ ] NO  [ ] YES

**KIDNEYS**  [ ] NO  [ ] YES

**HEADACHES/SEIZURES**  [ ] NO  [ ] YES

**PSYCHOLOGICAL DISORDERS**  [ ] NO  [ ] YES

**THYROID/DIABETES**  [ ] NO  [ ] YES

**BLOOD/BLEEDING DISORDER**  [ ] NO  [ ] YES

**FEMALES: ARE YOU PREGNANT?**  [ ] NO  [ ] YES

**PLAN TO BECOME PREGNANT?**  [ ] NO  [ ] YES

I authorize the Dermatology Service to release medical information to referring physicians.

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Patient’s Signature: ________________________  Today’s Date: ________________  Physician Signature: ________________  Today’s Date: ________________