**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? 

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**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 

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

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Please turn over and complete side 2

Revised 2/6/2015
Do you have a **personal history** of the following? | Yes | No |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Melanoma skin cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basal cell skin cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Squamous cell skin cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psoriasis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eczema</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does anyone in your **family** have a history of the following? | Yes | No | If yes, which family member? (ex. mother/father/sibling/child)
<table>
<thead>
<tr>
<th></th>
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<th></th>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**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:** Do you have any past or current problems with the following? Please describe:

<table>
<thead>
<tr>
<th>GENERAL HEALTH</th>
<th>☐ NO</th>
<th>☐ YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>EYES</td>
<td>☐ NO</td>
<td>☐ YES</td>
</tr>
<tr>
<td>EARS/NOSE/MOUTH/THROAT</td>
<td>☐ NO</td>
<td>☐ YES</td>
</tr>
<tr>
<td>HEART</td>
<td>☐ NO</td>
<td>☐ YES</td>
</tr>
<tr>
<td>LIVER</td>
<td>☐ NO</td>
<td>☐ YES</td>
</tr>
<tr>
<td>LUNGS</td>
<td>☐ NO</td>
<td>☐ YES</td>
</tr>
<tr>
<td>STOMACH/BOWELS</td>
<td>☐ NO</td>
<td>☐ YES</td>
</tr>
<tr>
<td>KIDNEYS</td>
<td>☐ NO</td>
<td>☐ YES</td>
</tr>
<tr>
<td>HEADACHES/SEIZURES</td>
<td>☐ NO</td>
<td>☐ YES</td>
</tr>
<tr>
<td>PSYCHOLOGICAL DISORDERS</td>
<td>☐ NO</td>
<td>☐ YES</td>
</tr>
<tr>
<td>THYROID/DIABETES</td>
<td>☐ NO</td>
<td>☐ YES</td>
</tr>
<tr>
<td>BLOOD/BLEEDING DISORDER</td>
<td>☐ NO</td>
<td>☐ YES</td>
</tr>
<tr>
<td>FEMALES: ARE YOU PREGNANT?</td>
<td>☐ NO</td>
<td>☐ YES</td>
</tr>
<tr>
<td>PLAN TO BECOME PREGNANT?</td>
<td>☐ NO</td>
<td>☐ YES</td>
</tr>
</tbody>
</table>

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

Patient's Signature ____________________________  Today's Date ____________  Physician Signature ____________________________  Today's Date ____________