Stephanie Lee, APRN

DERMATOLOGY NEW PATIENT MEDICAL HISTORY

Name _____ Date of Birth_____

Primary Care Doctor _____ Date_____

INSURANCE: _____

Did your doctor ask you (the patient) to see us or make this appointment? ☐No ☐Yes
If yes, please list your doctor's name and address: _____
_____

Reason for today's visit: _____

- How long has the problem been present? _____
- Where is it located? _____
- Symptoms: ☐Bleeding ☐Pain ☐Tingling ☐ Itching ☐Scaling ☐Crusting
  ☐Change in Size ☐Change in Color ☐Other _____
- Was a biopsy done? ☐No ☐Yes Results? _____
- Any previous treatments? ☐No ☐Yes If yes, what treatment and did it help? _____
  _____
- Check all of the following that apply to your (the patient's) risk factors for skin cancer:
  ☐Radiation treatments (not routine x-rays) ☐UV light treatments ☐Tanning bed use (current or past?)
  ☐Significant outdoor sun exposure ☐Immunosuppression ☐Arsenic exposure

Medical History:
Have you (the patient) or any member of your family (specify who) ever had any of the following conditions:

	PATIENT		**FAMILY MEMBERS - WHO?**		
	YES	NO	YES	NO	
Asthma	☐	☐	☐	☐	_____
Hay Fever	☐	☐	☐	☐	_____
Eczema	☐	☐	☐	☐	_____
Allergies	☐	☐	☐	☐	_____
Skin Cancer (not melanoma)	☐	☐	☐	☐	_____
Melanoma Skin Cancer	☐	☐	☐	☐	_____
Psoriasis	☐	☐	☐	☐	_____
Atypical Moles	☐	☐	☐	☐	_____
Keloids	☐	☐	☐	☐	_____

Other Skin Problems: _____
Other Cancers: _____

Check ALL that apply regarding your (the patient's) medical history and add any other medical problems:

CARDIOVASCULAR	YES	NO
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Defibrillator	☐	☐
High blood pressure	☐	☐
Stents	☐	☐
Murmur	☐	☐

INFECTIONS	YES	NO
Hepatitis	☐	☐
Tuberculosis	☐	☐
Staph infections	☐	☐
Sexually transmitted infection	☐	☐
HIV/AIDS	☐	☐

PSYCHIATRIC	YES	NO
Depression	☐	☐
Anxiety	☐	☐
Other psychiatric problems	☐	☐

ENDOCRINE	YES	NO
Diabetes	☐	☐
Thyroid disease	☐	☐

MUSCULOSKELETAL	YES	NO
Arthritis	☐	☐
Fibromyalgia	☐	☐
Artificial joint/Joint replacement	☐	☐

BLOOD/LYMPH	YES	NO
Anemia	☐	☐
Bleeding or Clotting disorder	☐	☐
Leukemia or Lymphoma	☐	☐

GYN (females only)	YES	NO
Pregnant	☐	☐
Nursing	☐	☐
Currently planning pregnancy	☐	☐

What form of birth control do you now use?
_____

☐OTHER _____

Review of Systems:
Check **ALL** that apply regarding your (the patient's) overall health:

	YES	NO		YES	NO
Chills	☐	☐	Vomiting	☐	☐
Fever	☐	☐	Easy bruising	☐	☐
Hives	☐	☐	Prolonged bleeding	☐	☐
Itching or red eyes	☐	☐	Muscle aches	☐	☐
Dry mouth	☐	☐	Painful joints	☐	☐
Excessive sweating	☐	☐	Headache	☐	☐
Diarrhea	☐	☐	Anxiety	☐	☐
Nausea	☐	☐	Depressed Mood	☐	☐

Social History

- Do you (the patient) smoke cigarettes? ☐Current ☐Past ☐Never If Current, how much? _____
- Does anyone living in your (the patient's) home smoke? ☐Yes ☐No
- Do you (the patient) drink alcohol? ☐Daily ☐Occasionally ☐Never
- Do you (the patient) use sunscreen? ☐Daily ☐Occasionally ☐Never
- What is your (the patient's) occupation? _____

Please list medications, dosages, & frequency (include over-the-counter meds, vitamins, supplements, etc.):

Please list allergies:

_____ _____ _____
Signature of Patient or Person Authorized to Sign | Relationship, if other than patient | Date

SHENANDOAH MEDICAL CENTER