

**NEW PATIENT DERMATOLOGY & MEDICAL HISTORY**

PATIENT NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

REFERRED BY: (PLEASE CIRCLE APPROPRIATE NUMBER)

- 1) PHYSICIAN: PHYSICIAN NAME: \_\_\_\_\_  
PHYSICIAN ADDRESS: \_\_\_\_\_
- 2) FRIEND/PATIENT: FRIEND.PATIENT NAME: \_\_\_\_\_
- 3) INSURANCE WEBSITE: \_\_\_\_\_ NEWSPAPER PHYSICIAN REFERRAL LINE

ARE YOU ALLERGIC TO ANY MEDICATIONS?  YES  NO  
IF YES PLEASE LIST: \_\_\_\_\_

HAVE YOU EVER HAD DENTAL ANESTHESIA (NOVOCAINE)?  YES  NO ANY BAD REACTIONS?  YES  NO

LIST ALL MEDICATIONS THAT ARE CURRENTLY TAKEN, INCLUDING PRESCRIPTIONS, ASPIRIN, OTC, VITAMINS & HERBS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TOPICAL MEDICATIONS OR PRODUCTS APPLIED TO THE SKIN: \_\_\_\_\_  
\_\_\_\_\_

CHIEF COMPLAINT	PROBLEM # 1	PROBLEM # 2
REASON FOR VISIT		
LOCATION OF PROBLEM		
LENGTH OF TIME PRESENT		
PRIOR TREATMENT		

WE RESPECT YOUR TIME AND MAKE EVERY EFFORT TO SEE PATIENTS IN A TIMELY MANNER, IN ORDER TO ACCOMPLISH THAT, DR. JACKSON WILL ADDRESS A MAXIMUM OF TWO PROBLEMS (ADDITIONAL CONCERNS WILL REQUIRE A SEPARATE APPOINTMENT)

DO YOU HAVE NOW, OR HAVE YOU EVER HAD THE DISEASES OR CONDITIONS OF (PLEASE CIRCLE YES OR NO)

CARDIOVASCULAR HISTORY:

- CARDIAC DISEASE  YES  NO
- ARTIFICIAL VALVE  YES  NO
- CARDIAC ARRHYTHMIAS  YES  NO
- HIGH BLOOD PRESSURE  YES  NO
- MVP/VALVE REPLACEMENT  YES  NO
- CARDIAC ARREST  YES  NO
- MYOCARDIAL INFARCTION  YES  NO
- DEFIBRILATOR  YES  NO
- PLEBITIS/BLOOD CLOT  YES  NO
- CARDIAC CATHETERIZATION  YES  NO
- HEART MURMUR  YES  NO
- ANGINA  YES  NO
- PACEMAKER  YES  NO
- HYPERTENSION  YES  NO

HEMATOLOGY/LYMPHATIC HISTORY:

- ANEMIA  YES  NO
- PROLONGED BLEEDING  YES  NO
- BLOOD TRANSFUSIONS  YES  NO
- DISEASES OF THE BLOOD  YES  NO
- HEPATITIS \_\_\_\_\_  YES  NO
- PROLONGED SWOLLEN LYMPH NODES  YES  NO

GI HISTORY:

- DISEASES OF THE LIVER  YES  NO
- DISEASES OF THE KIDNEY  YES  NO
- GI ULCER  YES  NO

NEUROLOGY HISTORY:

- SEIZURE DISORDERS  YES  NO
- NEUROMUSCULAR DISORDERS  YES  NO

RHEUMATOLOGY HISTORY:

- PAINFUL/SWOLLEN JOINTS  YES  NO
- ARTIFICIAL JOINT  YES  NO
- LUPUS  YES  NO

ENDOCRINE HISTORY:

- DIABETES  YES  NO
- CANCER/TUMORS  YES  NO
- IRREGULAR MENSTRUAL PERIODS  YES  NO
- INFERTILITY  YES  NO
- TYPE \_\_\_\_\_  YES  NO
- THYROID  YES  NO

IMMUNOLOGIC HISTORY:

- ORGAN TRANSPLANT  YES  NO
- HIV/AIDS  YES  NO

RESPIRATORY HISTORY:

- PULMONARY EMBOLISM  YES  NO
- ASTHMA  YES  NO
- COPD  YES  NO

PSYCHIATRIC HISTORY:

- DEPRESSION  YES  NO
- PSYCHIATRIC  YES  NO

**NEW PATIENT DERMATOLOGY & MEDICAL HISTORY (CONTINUED)**

**DERMATOLOGIC HISTORY:**

- |                               |  |                   |  |                                     |  |
|-------------------------------|--|-------------------|--|-------------------------------------|--|
| ACNE                          | <input type="checkbox"/> YES <input type="checkbox"/> NO | ABNORMAL MOLES    | <input type="checkbox"/> YES <input type="checkbox"/> NO | FLAKY SCALP                         | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ECZEMA                        | <input type="checkbox"/> YES <input type="checkbox"/> NO | FUNGAL INFECTIONS | <input type="checkbox"/> YES <input type="checkbox"/> NO | HERPES (COLDSORES)                  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| KELOIDS                       | <input type="checkbox"/> YES <input type="checkbox"/> NO | PRE CANCERS (AK)  | <input type="checkbox"/> YES <input type="checkbox"/> NO | PSORIASIS                           | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| WARTS                         | <input type="checkbox"/> YES <input type="checkbox"/> NO | ROSACEA           | <input type="checkbox"/> YES <input type="checkbox"/> NO | ULCERS                              | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| HIVES                         | <input type="checkbox"/> YES <input type="checkbox"/> NO | ATYPICAL MOLES    | <input type="checkbox"/> YES <input type="checkbox"/> NO |                                     |  |
| SKIN CANCER                   | <input type="checkbox"/> YES <input type="checkbox"/> NO | BASAL CELL        | <input type="checkbox"/> YES <input type="checkbox"/> NO | SQUAMOS CELL                        | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| MELANOMA                      | <input type="checkbox"/> YES <input type="checkbox"/> NO | RADIATION THERAPY | <input type="checkbox"/> YES <input type="checkbox"/> NO | TYPE _____                          |  |
| CHILDHOOD BLISTERING SUNBURNS | <input type="checkbox"/> YES <input type="checkbox"/> NO |                   |  | PERSISTENT ITCHING                  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| DISCOLORATION OF THE SKIN     | <input type="checkbox"/> YES <input type="checkbox"/> NO |                   |  | HYPERSENSITIVE SKIN                 | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ABNORMAL WOUND HEALING        | <input type="checkbox"/> YES <input type="checkbox"/> NO |                   |  | DRY SCALY SKIN                      | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ABNORMAL HAIR GROWTH          | <input type="checkbox"/> YES <input type="checkbox"/> NO |                   |  | WHERE ON FACE OR BODY _____         |  |
| NEW OR RECENTLY CHANGED MOLES | <input type="checkbox"/> YES <input type="checkbox"/> NO |                   |  | SEVERE SEASONAL DUST/DUST ALLERGIES | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| WHEN EXPOSED TO SUN, DO YOU?  | <input type="checkbox"/> TAN ONLY                        |                   | <input type="checkbox"/> TAN & BURN                      |                                     | <input type="checkbox"/> BURN                            |

**SKIN CANCER:**

LOCATION, DATE AND TREATMENT: \_\_\_\_\_

**OTHER CANCERS:**

**PLASTIC/COSMETIC SURGERY OR PROCEDURES:**

LOCATION, DATE, TREATMENT: \_\_\_\_\_

**OTHER MEDICAL CONDITIONS OR TREATMENT NOT LISTED ABOVE:**

**PAST SURGICAL HISTORY: LIST ANY PRIOR SURGERIES: LOCATION, DATE AND TREATMENT:**

**FAMILY HISTORY: PLEASE MARK ANY CONDITIONS ANYONE IN YOUR FAMILY HAS HAD:**

- |  |                                  |                                  |
|--|----------------------------------|----------------------------------|
| <input type="checkbox"/> ADOPTED HISTORY UNKNOWN   | <input type="checkbox"/> YES     | <input type="checkbox"/> NO      |
| <input type="checkbox"/> ABNORMAL MOLES            | <input type="checkbox"/> MOTHER  | <input type="checkbox"/> FATHER  |
| <input type="checkbox"/> ECZEMA                    | <input type="checkbox"/> MOTHER  | <input type="checkbox"/> FATHER  |
| <input type="checkbox"/> HAY FEVER                 | <input type="checkbox"/> MOTHER  | <input type="checkbox"/> FATHER  |
| <input type="checkbox"/> ASTHMA                    | <input type="checkbox"/> MOTHER  | <input type="checkbox"/> FATHER  |
| <input type="checkbox"/> PSORIASIS                 | <input type="checkbox"/> MOTHER  | <input type="checkbox"/> FATHER  |
| <input type="checkbox"/> SEVERE SEASONAL ALLERGIES | <input type="checkbox"/> MOTHER  | <input type="checkbox"/> FATHER  |
| <input type="checkbox"/> BASAL CELL CARCINOMA      | <input type="checkbox"/> MOTHER  | <input type="checkbox"/> FATHER  |
| <input type="checkbox"/> SQUAMOS CELL CARCINOMA    | <input type="checkbox"/> MOTHER  | <input type="checkbox"/> FATHER  |
| <input type="checkbox"/> MALIGNANT MELANOMA        | <input type="checkbox"/> MOTHER  | <input type="checkbox"/> FATHER  |
| <input type="checkbox"/> DYSPLASTIC NEVI           | <input type="checkbox"/> MOTHER  | <input type="checkbox"/> FATHER  |
| <input type="checkbox"/> ECZEMA                    | <input type="checkbox"/> MOTHER  | <input type="checkbox"/> FATHER  |
| <input type="checkbox"/> PSORIASIS                 | <input type="checkbox"/> MOTHER  | <input type="checkbox"/> FATHER  |
|  | <input type="checkbox"/> SIBLING | <input type="checkbox"/> SIBLING |
|  | <input type="checkbox"/> SIBLING | <input type="checkbox"/> SIBLING |
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|  | <input type="checkbox"/> SIBLING | <input type="checkbox"/> SIBLING |

**SOCIAL HISTORY:**

- |                                  |                                 |                                   |   |                                  |                                  |
|----------------------------------|---------------------------------|-----------------------------------|---|----------------------------------|----------------------------------|
| <input type="checkbox"/> MARRIED | <input type="checkbox"/> SINGLE | <input type="checkbox"/> DIVORCED | <input type="checkbox"/> WIDOWED        | <input type="checkbox"/> PARTNER | <input type="checkbox"/> ADOPTED |
| ARE YOU NURSING?                 | <input type="checkbox"/> YES    | <input type="checkbox"/> NO       | ARE YOU PREGNANT?                       | <input type="checkbox"/> YES     | <input type="checkbox"/> NO      |
| ARE YOU PLANNING A PREGNANCY?    | <input type="checkbox"/> YES    | <input type="checkbox"/> NO       |   |                                  |                                  |
| DO YOU USE TOBACCO?              | <input type="checkbox"/> YES    | <input type="checkbox"/> NO       | HOW MANY? _____                         | PER DAY/WEEK                     |                                  |
| DO YOU DRINK ALCOHOL?            | <input type="checkbox"/> YES    | <input type="checkbox"/> NO       | IF YES, _____                           | DRINKS PER DAY/WEEK              |                                  |
| DO YOU USE RECREATIONAL DRUGS?   | <input type="checkbox"/> YES    | <input type="checkbox"/> NO       | HAVE YOU EVER BEEN EXPOSED TO HIV/AIDS? | <input type="checkbox"/> YES     | <input type="checkbox"/> NO      |
| WHAT IS YOUR OCCUPATION?         | _____                           |                                   |   |                                  |                                  |
| WHAT ARE YOUR HOBBIES?           | _____                           |                                   |   |                                  |                                  |

**FORM COMPLETED BY**  PARENT OR GUARDIAN  
 MEDICAL ASSISTANT \_\_\_\_\_

\_\_\_\_\_  
**PATIENT OR GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**REVIEWED BY**