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 CIRLE YES OR NO)

CARDIOVASCULAR HISTORY:

CARDIAC DISEASE	□ YES □ NO	CARDIAC ARREST	□ YES □ NO	HEART MURMUR	□ YES □ NO
ARTIFICIAL VALVE	□ YES □ NO	MYOCARDIAL INFARCTION	□ YES □ NO	ANGINA	□ YES □ NO
CARDIAC ARRYTHMIAS	□ YES □ NO	DEFIBRILATOR	□ YES □ NO	PACEMAKER	□ YES □ NO
HIGH BLOOD PRESSURE	□ YES □ NO	PLEBITIS/BLOOD CLOT	□ YES □ NO	HYPERTENSION	□ YES □ NO
MVP/VALVE REPLACEMENT	□ YES □ NO	CARDIAC CATHERIZATION	□ YES □ NO		

HEMATOLOGY/LYMPHATIC HISTORY:

ANEMIA	□ YES □ NO	DISEASES OF THE BLOOD	□ YES □ NO		
PROLONGED BLEEDING	□ YES □ NO	HEPATITIS _____		□ YES □ NO	
BLOOD TRANSFUSIONS	□ 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	INFERTILITY	□ YES □ NO	THYROID	□ YES □ NO
CANCER/TUMORS	□ YES □ NO	TYPE _____			
IRREGULAR MENSTRUAL PERIODS		□ 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	☐ YES ☐ NO	ABNORMAL MOLES	☐ YES ☐ NO	FLAKY SCALP	☐ YES ☐ NO
ECZEMA	☐ YES ☐ NO	FUNGAL INFECTIONS	☐ YES ☐ NO	HERPES (COLDSORES)	☐ YES ☐ NO
KELOIDS	☐ YES ☐ NO	PRE CANCERS (AK)	☐ YES ☐ NO	PSORIASIS	☐ YES ☐ NO
WARTS	☐ YES ☐ NO	ROSACEA	☐ YES ☐ NO	ULCERS	☐ YES ☐ NO
HIVES	☐ YES ☐ NO	ATYPICAL MOLES	☐ YES ☐ NO		
SKIN CANCER	☐ YES ☐ NO	BASAL CELL	☐ YES ☐ NO	SQUAMOS CELL	☐ YES ☐ NO
MELANOMA	☐ YES ☐ NO	RADIATION THERAPY	☐ YES ☐ NO	TYPE _____	

CHILDHOOD BLISTERING SUNBURNS ☐ YES ☐ NO
DISCOLORATION OF THE SKIN ☐ YES ☐ NO
ABNORMAL WOUND HEALING ☐ YES ☐ NO
ABNORMAL HAIR GROWTH ☐ YES ☐ NO
NEW OR RECENTLY CHANGED MOLES ☐ YES ☐ NO
PERSISTENT ITCHING ☐ YES ☐ NO
HYPERSENSITIVE SKIN ☐ YES ☐ NO
DRY SCALY SKIN ☐ YES ☐ NO
WHERE ON FACE OR BODY _____
SEVERE SEASONAL DUST/DUST ALLERGIES ☐ YES ☐ NO
WHEN EXPOSED TO SUN, DO YOU? ☐ TAN ONLY ☐ TAN & BURN ☐ 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:
☐ ADOPTED HISTORY UNKNOWN ☐ YES ☐ NO

☐ ABNORMAL MOLES	☐ MOTHER	☐ FATHER	☐ SIBLING
☐ ECZEMA	☐ MOTHER	☐ FATHER	☐ SIBLING
☐ HAY FEVER	☐ MOTHER	☐ FATHER	☐ SIBLING
☐ ASTHMA	☐ MOTHER	☐ FATHER	☐ SIBLING
☐ PSORIASIS	☐ MOTHER	☐ FATHER	☐ SIBLING
☐ SEVERE SEASONAL ALLERGIES	☐ MOTHER	☐ FATHER	☐ SIBLING
☐ BASAL CELL CARCINOMA	☐ MOTHER	☐ FATHER	☐ SIBLING
☐ SQUAMOS CELL CARCINOMA	☐ MOTHER	☐ FATHER	☐ SIBLING
☐ MALIGNANT MELANOMA	☐ MOTHER	☐ FATHER	☐ SIBLING
☐ DYSPLASTIC NEVI	☐ MOTHER	☐ FATHER	☐ SIBLING
☐ ECZEMA	☐ MOTHER	☐ FATHER	☐ SIBLING
☐ PSORIASIS	☐ MOTHER	☐ FATHER	

SOCIAL HISTORY:
☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ PARTNER ☐ ADOPTED
ARE YOU NURSING? ☐ YES ☐ NO
ARE YOU PLANNING A PREGNANCY? ☐ YES ☐ NO
DO YOU USE TOBACCO? ☐ YES ☐ NO
DO YOU DRINK ALCOHOL? ☐ YES ☐ NO
DO YOU USE RECREATIONAL DRUGS? ☐ YES ☐ NO
ARE YOU PREGNANT? ☐ YES ☐ NO
HOW MANY? _____ PER DAY/WEEK
IF YES, _____ DRINKS PER DAY/WEEK
HAVE YOU EVER BEEN EXPOSED TO HIV/AIDS? ☐ YES ☐ NO
WHAT IS YOUR OCCUPATION? _____
WHAT ARE YOUR HOBBIES? _____

FORM COMPLETED BY ☐ **PARENT OR GUARDIAN**
☐ **MEDICAL ASSISTANT** _____

_____
PATIENT OR GUARDIAN SIGNATURE

_____
DATE

_____
REVIEWED BY