New Patient Questionnaire

DERMATOLOGY℠ & LASER CENTER

PERSONAL INFORMATION

Name: Age: DOB:

SS# Military Sponsor's SS# (If applicable):

Primary Physician: Referring Physician:

Primary Insurance: Secondary Insurance:

PAST MEDICAL HISTORY- **Check** each box for each medical condition you **have had (or currently have)** Please **BRIEFLY** explain all items checked.

- ☐ Depression/Psychiatric Disorders
- ☐ Heart Disease/Heart Attack
- ☐ Liver or Kidney Disease (Dialysis?)
- ☐ Muscle Disease
- ☐ Diabetes
- ☐ Bleeding Disorders
- ☐ Neurological Disease/Strokes/Seizures
- ☐ Artificial Heart Valves / Pacemaker
- ☐ Gastrointestinal Disease (i.e. Crohn's, IBS)
- ☐ Artificial Joints/Rheumatoid Arthritis
- ☐ Cancer (i.e. Breast, Colon, Lung, Prostrate)
- ☐ HIV/AIDS/Hepatitis/Tuberculosis
- ☐ Thyroid Disease/Endocrine Disorders
- ☐ Asthma/Emphysema/Lung Disease
- ☐ Genital or Urinary System Disease
- ☐ Autoimmune Disease (i.E. Lupus)
- ☐ High Blood Pressure
- ☐ Other (i.e. major surgeries, etc.)

Please explain all checked boxes:

☐ **Skin Disease**

Have you ever had skin cancer? ☐ Yes ☐ No If yes, please mark type (s) below:
☐ Melanoma ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Actinic Keratoses ☐ Other

Do you have a history of any specific skin diseases? ☐ Yes ☐ No Explain:

Has anyone in your family had skin cancer? ☐ Yes ☐ No Explain:

Is there a family history of skin disorders? ☐ Yes ☐ No Explain:
i.e. Psoriasis, eczema, Lupus, Vitiligo, etc.

Do you develop keloids (large scars) after surgery? ☐ Yes ☐ No Explain:

Do you develop skin reactions to: ☐ Medications ☐ Foods ☐ Environment ☐ Bandages ☐ Neosporin ☐ Other

ALLERGIES - are you allergic to any medications? If yes, please explain:

Have you ever had dental anesthesia (Novacaine)? ☐ Yes ☐ No Any Bad Reaction? ☐ Yes ☐ No

MEDICATIONS - Please list **all current medications** including prescription, over-the-counter, vitamins, and herbal supplements:

SOCIAL HISTORY

Current Occupation:

History of Outdoor Occupations (i.e. Farmer, Construction, Lifeguard, Fisherman, etc.):

Do you have any pets, farm animals or wild animals in or around the home? ☐ Yes ☐ No Explain:

Tobacco Use? ☐ Yes ☐ No How Much Daily? Alcohol Use? ☐ Yes ☐ No How Much Daily?

WOMEN = Are you currently **pregnant** (or breastfeeding) or planning on becoming pregnant in the near future? ☐ Yes ☐ No

Patient Phone Number(s): Home Work Cell

Patient Signature: Date:

Reviewed by Dermatology Provider: _____ Date: _____