College Park
Family Care
Center, P.A.

DERMATOLOGY NEW PATIENT MEDICAL HISTORY

Name ______________________________ Date ______________________________

Primary Care Doctor ______________________________

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 Who did the biopsy? ______________________________
- Are you treating with anything currently? ______________________________
- Any previous treatments? ☐ No ☐ Yes If yes, what was done and when? ____________________
  ____
- Check all of the following that apply to your (the patient's) risk factors:
  ☐ Radiation treatments (not routine x-rays) ☐ UV light treatments ☐ Arsenic exposure
  ☐ Significant outdoor sun exposure ☐ Immunosuppression ☐ Tanning bed use (current or past?) ☐ ☐

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

	YOU		FAMILY MEMBERS		WHO?
	YES	NO	YES	NO	
Asthma	☐	☐	☐	☐	________
Hay Fever	☐	☐	☐	☐	________
Eczema	☐	☐	☐	☐	________
Skin Cancer, including melanoma	☐	☐	☐	☐	________
Psoriasis	☐	☐	☐	☐	________
Atypical Moles	☐	☐	☐	☐	________
Keloids	☐	☐	☐	☐	________
Lupus	☐	☐	☐	☐	________

Other Skin Problems: ______________________________
Other forms of cancer: ______________________________

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	☐	☐

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	YES	NO
Heart attack	☐	☐
Stents	☐	☐
Other heart problems	☐	☐

GASTROINTESTINAL	YES	NO
Colitis	☐	☐
Celiac disease	☐	☐

RESPIRATORY	YES	NO
Emphysema	☐	☐
Asthma	☐	☐

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

NEUROLOGICAL	YES	NO
Stroke	☐	☐
Seizures	☐	☐
Alzheimer’s/dementia	☐	☐

PSYCHIATRIC	YES	NO
Depression	☐	☐
Anxiety	☐	☐
Other emotional/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	☐	☐

EAR	YES	NO
Hearing aids	☐	☐

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

What form of birth control do you now use? ______________________________

☐ OTHER ______________________________

See Reverse

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

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