Song Dermatology New Patient Health History Form

Full Name: ________________________________ Date of Birth: ___________________ Gender: ☐ Male ☐ Female
Height: _______ft _______inches Weight: ______________________ lbs
Home address: ____
Phone number: ____________________________ Email address: ____
Occupation: ____

Emergency contact name: _____________________ Phone #: ________________________ Relation: ___________________
Preferred Pharmacy Name & Address : ____
Pharmacy Phone #: ________________________

Referring Physician Name: _____________________________ Phone #: _____________________________
Primary Care Physician Name: _____________________________ Phone #: _____________________________
Reason for visit today: ____________________________
Have you seen other dermatologists for this? ☐ Yes ☐ No
Allergies: _____________________________

Current Medications (name and dose):

____
____

Past Medical Conditions (Check al that apply)

☐ None
☐ Arthritis
☐ Chronic obstructive lung disease (COPD)
☐ Depressive disorder
☐ Diabetes mellitus
☐ Elevated blood pressure
☐ End-stage kidney disease
☐ Hypertension (high blood pressure)
Other: Specify: _______________________
☐ HIV
☐ High cholesterol
☐ Leukemia
☐ Malignant lymphoma
☐ Malignant tumor of colon
☐ Hepatitis
☐ High cholesterol
☐ Hypothyroidism

Past Surgeries (Check all that apply)

☐ None
☐ Basal cell carcinoma excision
☐ Melanoma excision
☐ Squamous cell carcinoma excision
☐ History of colectomy
☐ Heart valve replacement
☐ Pacemaker ☐ Defibrillator
☐ Other surgeries : Specify: ____________________

[Gynecological]
☐ History of tubal ligation ☐ Hysterectomy
Are you currently pregnant or have any plans to become pregnant? ☐ Yes ☐ No

Skin Conditions

☐ None
☐ Acne
☐ Actinic keratosis
☐ Basal cell carcinoma of skin
☐ Squamous cell carcinoma of skin
☐ Dysplastic nevus of skin
☐ Eczema

Skin Protection
Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? ___________
Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have **family history of melanoma**? ☐ Yes ☐ No
If yes, how is he/she related to you? _______________

Social History
What is your smoking status?
☐ Never smoker ☐ Former smoker ☐ Current smoker (and if so, how many cigarettes per day? ____)

Do you drink alcohol?
☐ No ☐ Yes (and if so, how many drinks per week? ____)

Review of Systems
☐ Fever/chills
☐ Unintentional weight loss
☐ Night sweats
☐ Immunosuppression
☐ Cough
☐ Chest pain
☐ Thyroid Problems
☐ Bloody urine
☐ Problems with bleeding
☐ Problems with scarring
☐ Joint aches
☐ Seizures
☐ Depression
☐ Anxiety

Alerts
☐ Allergy to adhesive
☐ Allergy to lidocaine
☐ Artificial joints within past 2 years
☐ Artificial heart valve
☐ Defibrillator
☐ Pacemaker
☐ Rapid heart beat with epinephrine
☐ Blood thinners
☐ pregnant or planning to become pregnant

[QUALITY MEASURES]
For patients 65 and older: Have you received pneumonia vaccination? ☐ Yes ☐ No
[Advanced Care]
Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No
Do you have a living will? ☐ Yes ☐ No

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature ________________________________ Date _____________________________

Physician Reviewed: ______________________________Date _____________________________