DERMHOUSE
29355 Northwestern Highway, Suite 302 Southfield, MI. 48034
248-228-2990 phone 248-281-1764 fax
Robert Singer, M.D.
Daneen Locke, PA-C. Lisa Pilley, PA-C. Jenny Pateryn, PA-C.

NEW PATIENT HISTORY FORM

- Name: _____
- Main Reasons for coming to the office: _____

_____

- Location of Problem(s): _____
- Please briefly describe the problem(s):

_____

- How severe is your problem (please circle): mild / moderate / severe

- Duration of Problem (when did it first start?): _____
- Does it itch ? yes / no
- Is it painful ? yes / no
- Is it growing or changing? yes / no

- Select any of the following medical conditions that you currently have:

☐ Anxiety	☐ Hearing Loss
☐ Arthritis	☐ Hepatitis
☐ Asthma	☐ Hypertension
☐ Atrial Fibrillation (Irregular Heartbeat)	☐ HIV / AIDS
☐ BPH	☐ Hypercholesterolemia
☐ Bone Marrow Transplantation	☐ Hyperthyroidism
☐ Breast Cancer	☐ Hypothyroidism
☐ Colon Cancer	☐ Leukemia
☐ COPD	☐ Lung Cancer
☐ Coronary Artery Disease	☐ Lymphoma
☐ Depression	☐ Prostate Cancer
☐ Diabetes	☐ Radiation Treatment
☐ End Stage Renal Disease	☐ Seizures
☐ GERD	☐ Stroke

☐ Other (please explain) _____

☐ **NONE**

Please do not leave anything blank. If something does not apply please put N/A.

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● Name: _____

● Please list any prior surgeries and procedures (don't forget any heart, joint, skin procedures, C-section, tubal ligation, and hysterectomy).

_____

_____

FOR FEMALES ONLY:

Date of last Menstrual Period _____

Last Pelvic Exam _____

Last Mammogram _____

Last PAP smear _____

Number of Children (if applicable) _____

For all patients (again);

Birth Weight _____

Birth Age (gestation if known, usually 38-42 weeks, unless you were premature) _____

Any maternal illnesses during pregnancy? If yes, explain: _____

● Have you had any of the following skin conditions ?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous (atypical/dysplastic) Moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer
- ☐ Other (please explain) _____

Do you wear Sunscreen? _____ yes _____ no
If yes, what SPF? _____
Do you tan in a tanning salon? _____ yes ____ no

Please do not leave anything blank. If something does not apply please put N/A.

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● Name: _____

● Family History

Do you have a family history of Melanoma?

O yes O no

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Other _____
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter

● Please list your medications and supplements (and the month and year you began each one. This is very important. Don't forget OTC products like aspirin, ibuprofen, Tylenol. Also put in any medications you have stopped within the last 6 months). Please let us know the dose and frequency you are taking these!

_____

_____

_____

_____

● Are you allergic to any medications? yes / no

If so, please list the date or year you had the reaction and what kind of symptoms you had, such as rash, itching, hives, shortness of breath, nausea, etc.

_____

_____

● Name: _____

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● Do you smoke or chew tobacco: yes / no / quit

If quit, when did you start? _____

When did you quit? _____

If you ever smoked, how many packs a day? _____

How many years did you smoke? _____

● Do you drink alcohol: yes / no / quit

If you drink, how many drinks per day? ____<1 _____ 1-2 _____ 3 or more

● Do you feel safe at home ____ yes ____ no. Please explain if no _____

● Do you drive (if age appropriate) ____ yes ____ no

If so, do you drive at night? ____ yes _____ no

● How often do you exercise?

___ never ____ once a day ___ several times per day ___ a few times a week ___ a few times a month

● What is your caffeine use?

___ never ____ once a day ___ several times per day ___ a few times a week ___ a few times a month

Please continue to page 5

● Name: _____

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Do you have ? (please circle):

● Do you allergy to adhesive?	yes / no	If yes, explain _____
● Do you have allergy to lidocaine?	yes / no	If yes, explain _____
● Do you have allergy to topical antibiotics?	yes / no	If yes, explain _____
● Do you have an artificial heart valve?	yes / no	If yes, explain _____
● Do you have artificial joints within the past two years ?	yes / no	If yes, explain _____
● Are you on blood thinners ?	yes / no	If yes, explain _____
● Do you have a defibrillator?	yes / no	If yes, explain _____
● Do you have a history of MRSA?	yes / no	If yes, explain _____
● Do you have a pacemaker?	yes / no	If yes, explain _____
● Do you premedicate before procedures?	yes / no	If yes, explain _____
● Do you get a rapid heartbeat with epinephrine (dentist, etc) ?	yes / no	If yes, explain _____
● Did you recently travel to West Africa or have contact with someone who did?	yes / no	If yes, explain _____
● Do you have a recent history of a fever >100.4 F or 38 C?	yes / no	If yes, explain _____
● Do you have any risk of recent contact with anyone known to have Ebola or with symptoms of this?	yes / no	If yes, explain _____
● Do you have problems with healing?	yes / no	If yes, explain _____
● Do you have problems with bleeding?	yes / no	If yes, explain _____
● Do you have problems with healing (scars/keloids) ?	yes / no	If yes, explain _____
● Do you have a rash?	yes / no	If yes, explain _____
● Do you have a immunosuppression meaning recent chemotherapy or medications which lower the immune system?	yes / no	If yes, explain _____
● Do you have hay fever?	yes / no	If yes, explain _____
● Do you have chest pain ?	yes / no	If yes, explain _____
● Do you have fever or chills ?	yes / no	If yes, explain _____
● Do you have night sweats?	yes / no	If yes, explain _____
● Do you have unintentional weight loss?	yes / no	If yes, explain _____
● Do you have thyroid problems?	yes / no	If yes, explain _____
● Do you have a sore throat?	yes / no	If yes, explain _____
● Do you have blurry vision?	yes / no	If yes, explain _____
● Do you have nausea or upset stomach?	yes / no	If yes, explain _____
● Do you have bloody stools?	yes / no	If yes, explain _____
● Do you have bloody urine?	yes / no	If yes, explain _____
● Do you have joint pain?	yes / no	If yes, explain _____

● Name: _____

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Do you have ? (please circle):

● Do you have muscle weakness?	yes / no	If yes, explain _____
● Do you have neck stiffness?	yes / no	If yes, explain _____
● Do you have headaches?	yes / no	If yes, explain _____
● Do you have a history of seizures?	yes / no	If yes, explain _____
● Do you have a cough?	yes / no	If yes, explain _____
● Do you have shortness of breath?	yes / no	If yes, explain _____
● Do you have wheezing?	yes / no	If yes, explain _____
● Do you have anxiety (especially at a doctor's office) ?	yes / no	If yes, explain _____
● Do you have depression?	yes / no	If yes, explain _____
● Do you have a changing mole ?	yes / no	If yes, explain _____

Females only (this applies to all females age 10 and older):

● Are you pregnant? yes / no If yes, explain _____
● Are you planning a pregnancy? yes / no If yes, explain _____
● When is the last date of your period (or last period if menopausal) ___/___/_____
● If you are avoiding pregnancy, what method are you using, such as birth control pills, IUD, abstinence, Depo-Provera, condoms, or other: _____
● Are you breastfeeding? yes / no If yes, explain _____

*****FOR ALL AGAIN:*****

● Who referred you to this office?

_____

● Please list the name, phone, and fax (if known) of any doctors who should receive a note about today's visit.

_____

_____

Please list the name, address and phone number of your preferred pharmacy:

_____

Please do not leave anything blank. If something does not apply please put N/A.