DERMHOUSE
29425 Northwestern Highway, Suite 202
Southfield, MI. 48034
248-219-7007 phone 866-410-6205 fax

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**

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

_____

_____

● 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) _____
- ☐ **NONE**

Do you wear Sunscreen?
O yes O no

If yes, what SPF?
☐ SPF

Do you tan in a tanning salon?
O yes O no

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● 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):

_____

_____

_____

_____

● 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.

_____

_____

● Do you smoke or chew tobacco: yes / no / quit If yes (or you quit), please explain _____

_____

● Do you drink alcohol: yes / no / quit If yes (or you quit), please explain _____

_____

● Name: _____

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Do you have ? (please circle):

● Do you have a pacemaker ?	yes / no	If yes, explain _____
● Do you have a defibrillator ?	yes / no	If yes, explain _____
● Do you have an artificial heart valve ?	yes / no	If yes, explain _____
● Do you have any artificial joints within the last year ?	yes / no	If yes, explain _____
● Do you take premedication prior to procedures ?	yes / no	If yes, explain _____
● Are you allergic to adhesive ?	yes / no	If yes, explain _____
● Are you allergic to topical antibiotics ?	yes / no	If yes, explain _____
● Are you on blood thinners ?	yes / no	If yes, explain _____
● Do you have other bleeding problems ?	yes / no	If yes, explain _____
● Do you get a rapid heartbeat with epinephrine (dentist, etc) ?	yes / no	If yes, explain _____
● Do you get yeast infections with antibiotics ?	yes / no	If yes, explain _____
● Do you get GI upset with antibiotics ?	yes / no	If yes, explain _____
● Are you allergic to lidocaine ?	yes / no	If yes, explain _____
● Do you have problems with healing (scars/keloids) ?	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 _____

● 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, city, zip code and phone number of your preferred pharmacy(s):

_____