Banner Health

NEW PATIENT MEDICAL HISTORY - DERMATOLOGY

Patient Name: _____ Date of Birth:_____

Gender Identity (Optional) _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Primary Care Provider: _____

Preferred Pharmacy (name and location): _____

Reason for today's visit _____

Do you have: Advanced Directive ❑ Yes ❑ No Living will ❑ Yes ❑ No Medical Power of Attorney ❑ Yes ❑ No

If no, would you like additional information? ❑ Yes ❑ No

Email address: _____

Would you give us permission to email you about monthly promotions and special events? ❑ Yes ❑ No

MEDICATIONS

❑ Not taking any medications

List any medications, vitamins, supplements and over the counter medicines you are taking, with dose and how often.

Medication Name:	Dose:	How often?

ALLERGIES

❑ No known allergies List any allergies and intolerances to medications, food or the environment.

Allergy:	Reaction:

MEDICAL HISTORY

List any current or past medical conditions (please place checkmark by any current problems).

❑ _____ ❑ _____

❑ _____ ❑ _____

❑ _____ ❑ _____

PREVIOUS SKIN CANCER HISTORY

Type of Skin Cancer:	Location:	Date:	Treatment?

DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD

9999-0189
(08/2018)

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SURGICAL HISTORY

List any past surgical procedures you have had

❑ None

FAMILY HISTORY

List health conditions for each family member.

	Alive	Deceased	Age of Death	Health Condition(s)	History of Skin Cancer
Father					
Mother					
Brothers					
Sisters					

Family History Skin Cancer

Check all that apply

	Atypical Nevi	Basal Cell	Squamous Cell	Melanoma	Other
Father					
Mother					
Brothers					
Sisters					

SOCIAL HISTORY

TOBACCO / ALCOHOL / CAFFEINE / DRUGS

Tobacco/smoking status: ❑ Never ❑ Current ❑ Former

Type _____ Amount _____ Duration _____

Do you drink alcohol? ❑ Yes ❑ No

If yes, type _____ Amount _____ Frequency _____

Do you drink Caffeine? ❑ Yes ❑ No

If yes, type _____ Amount _____ Frequency _____

Do you use recreational drugs? ❑ Yes ❑ No

If yes, type _____ Amount _____ Frequency _____

Are you on a special diet? ❑ Yes ❑ No If yes, What kind _____

Do you exercise? ❑ Yes ❑ No If yes, type(s) _____ Hours per Week _____

Do you use sunscreen? ❑ Yes ❑ No

Do you currently, or in have you in the past used a tanning bed? ❑ Yes ❑ No

Are you exposed to fumes, dust, solvents, or any airborne particles? ❑ Yes ❑ No

Your Occupation: _____

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REVIEW OF SYSTEMS

Please mark any of the following symptoms you have had in the last **4 weeks.**

	CONSTITUTIONAL
	Chills
	Fatigue
	Fever
	Night sweats
	Weight gain
	Weight loss
	EYES
	Eye discharge
	Red eyes
	Itchy eyes
	Swollen eyes
	Eye pain
	Visual changes
	EARS/NOSE/MOUTH/THROAT
	Ear discharge
	Ear pain
	Hearing loss
	Mouth sores
	Nasal congestion
	Sore throat
	RESPIRATORY
	Cough
	Shortness of breath
	Wheezing
	CARDIOVASCULAR
	Chest pain
	Heart trouble
	Irregular heartbeat
	Swelling of feet, ankles or hands
	GASTROINTESTINAL
	Abdominal pain
	Blood in stool
	Change in stools
	Constipation
	Diarrhea
	Heartburn
	Loss of appetite
	Nausea
	Vomiting

	GENITOURINARY
	Blood in urine
	Burning/pain with urination
	Frequent urination
	Incontinence
	Painful urination
	MALE
	Erectile dysfunction
	Penile discharge
	FEMALE
	Abnormal bleeding
	Breast discharge
	Breast lump
	Hot flashes
	Irregular menses
	Painful menses
	Painful intercourse
	Currently pregnant
	Currently breastfeeding
	Considering pregnancy
	Vaginal discharge
	ENDOCRINE
	Brittle hair
	Brittle nails
	Cold intolerance
	Excessive hair growth
	Excessive hunger
	Excessive sweating
	Excessive thirst
	Heat intolerance
	HEMATOLOGIC
	Easy bruising
	Easy bleeding
	Swollen lymph glands

	MUSCULOSKELETAL
	Back pain
	Joint pain
	Limited joint movement
	Joint stiffness/swelling
	Muscle pain
	Muscle weakness
	Neck pain
	SKIN
	Discoloration
	Hair loss
	Itching
	Mole changes
	Rash
	Skin sores
	NEUROLOGICAL
	Difficulty walking
	Dizziness
	Headaches
	Memory loss
	Numbness
	Tremors
	PSYCHIATRIC
	Anxiety
	Depression
	Insomnia
	Memory loss
	IMMUNOLOGICAL
	Contact allergies
	Environmental allergies
	Food allergies
	OTHER

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