

CENTER FOR DERMATOLOGY AND LASER SURGERY, P.C.  
New Patient History

NAME \_\_\_\_\_ M/F Date of Birth \_\_\_/\_\_\_/\_\_\_ Date of visit \_\_\_/\_\_\_/\_\_\_

Consult from Dr: \_\_\_\_\_ Your age: \_\_\_\_\_

**PROBLEM 1:** \_\_\_\_\_

Location: \_\_\_\_\_ Symptoms: (pain, bleeding, itching, growing, changing, spreading)

Duration: \_\_\_\_\_ (# of days/weeks/months/years) Severity (1-10): \_\_\_\_\_ Prior evaluation: \_\_\_\_\_

Previous treatments: \_\_\_\_\_

Does anything make this better or worse? \_\_\_\_\_

**PROBLEM 2:** \_\_\_\_\_

Location: \_\_\_\_\_ Symptoms: (pain, bleeding, itching, growing, changing, spreading)

Duration: \_\_\_\_\_ (# of days/weeks/months/years) Severity (1-10): \_\_\_\_\_ Prior evaluation: \_\_\_\_\_

Previous treatments: \_\_\_\_\_

Does anything make this better or worse? \_\_\_\_\_

**PROBLEM 3:** \_\_\_\_\_

Location: \_\_\_\_\_ Symptoms: (pain, bleeding, itching, growing, changing, spreading)

Duration: \_\_\_\_\_ (# of days/weeks/months/years) Severity (1-10): \_\_\_\_\_ Prior evaluation: \_\_\_\_\_

Previous treatments: \_\_\_\_\_

Does anything make this better or worse? \_\_\_\_\_

Please list any **DRUG ALLERGIES** you have (i.e., antibiotics, aspirin, pain medication, iodine/Betadine, Neosporin, etc.)

List **all** prescription and over-the-counter medications you take for any reason:

**Over-->**

Your NAME \_\_\_\_\_ Date of birth: \_\_\_\_\_

Your PCP: \_\_\_\_\_ Phone: \_\_\_\_\_

Your PCP's address: \_\_\_\_\_

**DO YOU currently or have you ever had the following:**

Yes		No		Yes		No		Yes		No	
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	Atopic Derm/Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A/B/C	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Type of skin cancer and location:			Cancer (other)	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Persistent yeast infections	<input type="checkbox"/>	<input type="checkbox"/>
			<i>Type:</i>			HIV/Aids	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic Ovarian disease	<input type="checkbox"/>	<input type="checkbox"/>
			Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Enlargement	<input type="checkbox"/>	<input type="checkbox"/>
			<i>Type:</i>			Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
			Deep Vein thrombi	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
			Depression	<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppressed	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<i>Why:</i>			Shell Fish Allergy	<input type="checkbox"/>	<input type="checkbox"/>
			Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	Irritation with Tape	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Anesthesia reaction	<input type="checkbox"/>	<input type="checkbox"/>	Genital warts	<input type="checkbox"/>	<input type="checkbox"/>	Keloid	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Have trouble healing	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<b>For Females:</b>		
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve Problems	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Trying to become pregnant	<input type="checkbox"/>	<input type="checkbox"/>

**Other:**

List any **SURGICAL PROCEDURES** you have had:

Your Occupation: \_\_\_\_\_

Tobacco use: N / Y \_\_\_\_\_ (frequency)

Alcohol: N / Y \_\_\_\_\_ (frequency)

**Circle your sun exposure over your lifetime:**

Average      Moderate      Severe

History of blistering sunburns:    Yes    /    No

**Do you have any immediate family members with the following:**

Yes		No		Yes		No		Yes		No	
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Polycystic ovarian disease	<input type="checkbox"/>	<input type="checkbox"/>
<i>List type and in whom:</i>			Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
			Atopic derm/Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
			Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
			Deep Vein Thrombi	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>