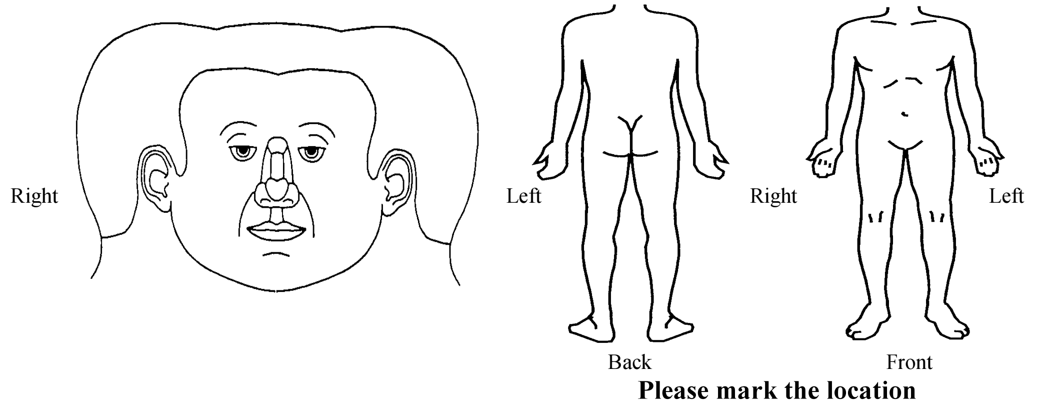
Initial Visit
New Patient
History Form

Date .... **Patient** .... **Date of Birth** .... **Referred by** *none* or **Dr.** ....

Chief Complaint **Circle & describe ➔** Acne Spot Mole Wart Growth Rash Itching &/or other Please list below.



History of Present Illness:

Please mark the location

Proper Skin Exam usually requires partial or complete undressing. Please let the staff know if you need assistance.

Problem **Please circle** Acne Spot Mole Wart Growth Rash Itching &/or other Please list:

Location *(Site-Where?)* Generalized Multiple As marked above or List:

Duration *(How Long? When?)* ....days ....weeks ....months ....years *unknown*

Timing Acute Chronic Persistent Recurrent **Onset** Sudden Gradual

Quality No-Symptoms Itching Irritating Painful Non-Healing Changing Suspicious
Unsightly Bothersome Upsetting &/or list:

Severity Mild Moderate Severe Extensive **Extent** Generalized Localized

Context: Any special Association/Context: *None Unknown* or list:

Modifying Factors

Aggravated by: *None Unknown* Nerves Stress Menses Contact Allergy Plants
Chemicals Work Sports Hobbies Pets Drugs &/or list:

Improved by: *None Unknown* Meds OTC Home remedies Other Please list:

Associated Signs & Symptoms *None* Itching Pain Abnormal Sensation Weakness
Other Please list:

Other Signs & Symptoms *None* Psychological Social &/or other list details:

Dermatologists &/or Physicians seen *None* or list details:

Present Skin Diagnoses & Treatments *None* or list details:

Past Skin Diagnoses & Treatments *None* Same or list details:

Any other relevant information *None* or list:

Any other information you wish us to know *None* or list:

Initial Visit
Past, Family & Social
History Form

Date .... **Patient** .... **Date of Birth** .... **Referred by** *none* or **Dr.** ....

Past, Family & Social History
List of Current Medications, Drug Allergies & Other Contraindications
Circle &/or Describe

Past and Present Problems *None* Psych/Neuro Depression Memory Alzheimer Seizures Dizzy Spells Headaches Stroke Diabetes Thyroid Hormone ENT Hearing Mouth Teeth High Blood Pressure Cholesterol Heart Disease Heart Attack Irregular Heart Beat Palpitations Murmur MVP Bypass Pacemaker Shortness of Breath Asthma Anemia Lymph Nodes Cancer Arthritis Lupus Muscle Bone Prostate Kidney Urinary Genital Digestive Reflux Gerd Peptic Ulcers Colitis Cataract Glaucoma Allergies Hay fever Hepatitis B C TB HIV STDs Infectious Diseases General Constitution Recent Weight Loss Weight Gain Tired Fever Frail Obese Disabled Radiation Surgeries & others. Please write down all your symptoms & medical problems or provide a list.

Family Hx *None* Adopted Acne Eczema Dermatitis Psoriasis Allergies Drug Reactions Fungus Abnormal Moles Melanoma Skin Cancer Lupus Hair Loss Thyroid Disease Arthritis Diabetes Heart Disease High BP Stroke Seizures Cancer Glaucoma Cataract Keloids Unknown Similar Same &/or Other Hereditary/Familial Disorders. Please list names of all family conditions:

Social Hx **Marital Status:** s m d w **Education &/or Occupation:** Child Student Home Retired Disabled None or list: ....
Sun Protection yes no **Exercise** yes no **Tobacco** yes no **Alcohol** yes no **Pets** no yes .... **Hobbies & Sports:** *None* or list:....................
Foreign Travel no yes .... **Any exposure to TB, Hepatitis, HIV etc** no yes .... **Any other relevant information:** *None* or list:

Surgery Patients High BP Angina Heart-Circulation Irregular Heart Beat Stroke Palpitations Diabetes Infection Fainting Implants Prosthetics Dizzy Spells Blood Thinners Aspirin Arthritis-meds Cortisone Bleeding Poor Healing Lumpy Scars Keloids
Any Reaction to: Lidocaine Anesthetics Epinephrine Antiseptics Band-Aids Tapes Antibiotics *None* &/or others Please list below.

Female Patients **Pregnant** No Yes months **Breast Feeding** No Yes months **Planning Pregnancy** when? **Frequent Yeast Infection** Yes No
Birth Control *None* No-Sex Menopause Uterus-Removed Tubes-Tied Patch IUD Husband-Fixed Condom or **Pill-Brand name** for Years

Drug Allergies *None* Penicillin Tetracycline Sulfa Erythromycin Cephalosporin Doxycycline Minocycline Epinephrine Cortisone Antihistamines Anesthetics Codeine Topical medications &/or others Please list generic &/or brand names of all products:

Medications *None* Psych/Neuro Heart Circulation Blood Pressure Seizure Diabetes Pain Infections Arthritis Allergy HRT Steroids Weight Loss Drugs Prescriptions Non-Prescriptions Over-the-Counter Home Remedies Street Drugs Narcotics Alcohol Tobacco &/or Others Please write down generic &/or brand names of all products or provide a list.

Do you have any questions, comments or suggestions? No Yes Please list:

Initial Visit
Review of Systems
History Form

Date .... **Patient** .... **Date of Birth** .... **Referred by** *none* or **Dr.** ....

Review of Systems
Circle &/or Describe

Skin: Acne Spot Mole Wart Growth Rash Itching &/or other
Please describe ➔

General: Itching Pain Exhaustion Fatigue Malaise Weight Gain/Loss Headache Fever *None* &/or other
Please describe ➔

Allergic/Immunologic: Urticaria Hay fever Hives Persistent infections Hepatitis B C TB HIV *None* &/or other
Please describe ➔

Eyes: Swelling Eyelids Heliotrope Irritation Redness Vision loss Pain Glaucoma *None* &/or other
Please describe ➔

ENT: Pain Swelling Hearing Loss Nosebleeds Sore throat Hoarseness Dysphagia *None* &/or other
Please describe ➔

Cardiovascular: Chest pains Palpitations Syncope Leg Cramps Varicose Veins Peripheral edema *None* &/or other
Please describe ➔

Respiratory: Shortness of Breath Cough Blood in sputum wheezing Asthma *None* &/or other
Please describe ➔

Gastrointestinal: Nausea Ulcer Cramps Pain Bleeding Change in bowel habits *None* &/or other
Please describe ➔

Genitourinary: Enlarged prostate Urinary Problem Irregular Periods Abnormal Bleeding *None* &/or other
Please describe ➔

Musculoskeletal: Joint pain swelling Stiffness Arthritis Muscle weakness *None* &/or other
Please describe ➔

Neurologic: Stroke Weakness Abnormal sensation Pain Paresthesias Seizures Dizziness *None* &/or other
Please describe ➔

Psychiatric: Anxiety Fear Forgetfulness Depression Suicidal ideation *None* &/or other
Please describe ➔

Endocrine: Intolerance to Heat/Cold Excessive thirst/appetite/urination Weight Gain/Loss *None* &/or other
Please describe ➔

Heme/Lymphatic: Abnormal Bruising Bleeding Enlarged lymph nodes *None* &/or other
Please describe ➔

Dermatology Exam & Management

Patient Name:

Date of Birth:

Date of Exam:

Chaperone/Scribe:

Culturally Sensitive Exam

Spot Evaluation Only

Right Left

Left Right Left

Back Right

Constitutional-General Appearance

		Yes	No
Build, Nutrition, Posture, Grooming	Normal		
Vital Signs Wt. Pulse, BP, Temp			

Neuro/Psychiatric

		Yes	No
Alert & Oriented in T/S/P	Normal		
Mood and Affect	Normal		

Eyes

		Yes	No
Eyelids and Conjunctivae	Normal		

Hair & Sweat Glands

		Yes	No
Scalp & Body Hair	Normal		
Eccrine & Apocrine Glands	Normal		

Skin & Subcutaneous Tissues

		Yes	No
Blemishes, Rashes, Lesions, Photodamage etc			
Head & Face	Normal		
Neck	Normal		
Chest, Breast & Axillae	Normal		
Abdomen	Normal		
Genitalia, Groin & Buttcks	Normal		
Back	Normal		
Right Upper Extremity	erm		
Left Upper Extremity	Normal		
Right Lower Extremity	Normal		
Left Lower Extremity	Normal		

Cadiovascular (Peripheral)

		Yes	No
No edema, Circulation ok	Normal		

Extremities

		Yes	No
No digital cyanosis or clubbing	Normal		

Ear, Nose, Mouth & Throat

		Yes	No
Lips, Teeth and Gums	Normal		
Oropharynx	Normal		

Neck

		Yes	No
Thyroid, nodules or masses	Normal		

Lymph Nodes

		Yes	No
1-Neck 2-Axillae 3-Groin	Normal		

Gastrointestinal

		Yes	No
No anal growths or fissures	Normal		
No hepatosplenomegally	Normal		

Comprehensive Derm Exam requires evaluation of all above areas.

Referrals are made for Complete Medical Evaluations & Procedures

Pertinent Details

Clinical Impression

Management Plan

Rx CME Labs KOH C&S Bx Surg

Follow Up

Week Month PTC PCP REF