New Patient Medical History **DATE: ____/____/____**

Name: (Last)_____ (First)_____ I was referred here today by Dr._____

Date of Birth: ____/____/____ Sex: M/F/_____ Immediate family member treated here: _____

1. Drug Allergies: ____ NO ☐ YES ☐ LIST: _____

2. Vaccines (list date): FLU _____ COVID19 _____ SHINGLES _____ PNEUMONIA: _____

3. Medications: (include herbals, vitamins, birth control. over the counter products, and products used on the skin)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

4. Past Medical History: Check diseases that you have or had

NONE.....	☐	Cancer (skin)		**Hepatitis**.....	☐
Acne, scarring	☐	A. BCC.....	☐	High Blood Pressure.....	☐
Allergies (seasonal).....	☐	B. SCC.....	☐	High Cholesterol.....	☐
Anxiety.....	☐	C. Melanoma.....	☐	**HIV**.....	☐
Arthritis.....	☐	Celiac Disease.....	☐	Hyperthyroidism.....	☐
Arthritis, Osteo.....	☐	Depression.....	☐	Hypothyroidism.....	☐
Arthritis, Rheumatoid.....	☐	Diabetes.....	☐	Lung Disease.....	☐
Asthma.....	☐	Eczema.....	☐	Lupus.....	☐
Cancer (non-skin).....	☐	Exercise Counseling.....	☐	Psoriasis.....	☐
A. Type:_____		Heart Disease.....	☐	Other:_____	

5. Past Surgical History

Appendectomy.....	☐
C-Section (s).....	☐
Gallbladder.....	☐
Heart Bypass Surgery	☐
Hernia Repair.....	☐
Hip Replacement.....	☐
Hysterectomy.....	☐
Knee Replacement.....	☐
Skin Cancer Surgery	☐
Other:_____	

6. Family Medical History: (check answers)

	Father	Mother	Brother	Sister
Arthritis	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Eczema	☐	☐	☐	☐
Hair loss	☐	☐	☐	☐
Hay fever/Allergies	☐	☐	☐	☐
Lupus	☐	☐	☐	☐
Melanoma	☐	☐	☐	☐
Other Skin Cancer	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐
Thyroid disorder	☐	☐	☐	☐

7. Females Only: (check or write answers)

Are you pregnant?	Yes ☐	No ☐
Breastfeeding?	Yes ☐	No ☐
Are you Menopausal?	Yes ☐	No ☐
Are your periods regular?	Yes ☐	No ☐
	Prepubescent (no period yet) ☐	
If irregular, please explain:_____		

Birth Control Method:	None ☐		Abstinence ☐
Tubal Ligation ☐	Oral (pill) ☐		Nuva Ring ☐
Hysterectomy ☐	IUD ☐		Tubal Ligation ☐
Vasectomy ☐	Condoms ☐		Depo provera (shot) ☐
Other: _____			

8. Social History (circle, check or write an answer)

Marital Status: S M D W

Occupation:_____

Do you smoke tobacco? Yes ☐ No ☐ Former ☐

If yes, packs per day = _____

9. Sun Exposure: (circle/check answers)

Amount: (minimal) (moderate) (excessive) (work outside)

History of Sunburn: (none) (childhood) (teens) (adult) (last yr)

Hx of Blistering: (I have blistered) (I have not blistered)

Do you use sunscreen? Yes ☐ No ☐

Do you use tanning beds? Yes ☐ No ☐ In past ☐

10. Review of Systems: Have you **recently experienced** any of the following? (If yes, check the box and explain)

General Health		**GU-Kidney**	
A. Fever	☐ _____	A. Frequent Urination	☐ _____
B. Weight gain	☐ _____	B. Burning with urination	☐ _____
C. Weight loss	☐ _____	C. Bloody Urine	☐ _____
D. Fatigue	☐ _____	**Arthritis/Muscles/Joints**	
Eyes		A. Joint Pain	☐ _____
A. Dry eyes	☐ _____	B. Muscle Pain	☐ _____
B. Gritty sensation	☐ _____	C. Muscle weakness	☐ _____
Ear, Nose, Throat		**Psychological Disorder**	
A. Dry Mouth	☐ _____	A. Stress	☐ _____
B. Hearing loss	☐ _____	B. Anxiety	☐ _____
Cardiovascular		C. Panic attacks	☐ _____
A. Swelling of feet	☐ _____	D. Depression	☐ _____
B. Swelling of legs	☐ _____	**Endocrine Disease**	
C. Calf pain	☐ _____	A. Increased thirst	☐ _____
Stomach-Bowel		B. Heat Intolerance	☐ _____
A. Bloody stools	☐ _____	C. Cold Intolerance	☐ _____
B. Diarrhea	☐ _____	D. Change in hair or nails	☐ _____
C. Gas	☐ _____	**Allergy/Immunology**	
D. Bloating	☐ _____	A. Itchy, watery eyes	☐ _____
E. Nausea	☐ _____	B. Runny nose, wheezing	☐ _____