New Patient Health Questionnaire

All information collected is strictly confidential and will become part of your medical record. Please bring completed form to your appt.

Patient Data

Last Name:_____________________________ First Name:____________________ Middle Initial:____

Date of Birth:___________________________ Gender: M F

Race: White | Black or African American | Pacific Islander | Hispanic or Latino origin | Asian | Other

Past Medical History: Check all that apply

Anxiety/Depression	Bone Marrow Transplant	Depression	Hypertension
Arthritis	Breast Cancer	Diabetes	HIV/AIDS
Asthma	Colon Cancer	GERD	Hyperthyroid
Atrial Fibrillation	COPD	Hearing Loss	Hypothyroid
BPH	Coronary Artery Disease	Hepatitis B or C	Leukemia/Lymphoma
Radiation Treatment	Prostate Cancer	Seizures	Stroke
High Cholesterol	Dialysis	Kidney Transplant	Other:_____________

Past Surgical History

Have you had any surgeries? If so, what and when?

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Skin Disease History: Check all that apply

Acne	Eczema	Melanoma
Actinic Keratosis	Flaking or itchy scalp	Basal Cell Skin Cancer
Blistering sunburns	Psoriasis	Squamous Cell Skin Cancer
Dry Skin	Contact Dermatitis	Precancerous Moles
Alopecia	Other:________________________	

Do you wear Sunscreen? Y N If yes, what SPF? ___________________________

Do you tan in a tanning salon? Y N

Is there a family history of melanoma? Y N If yes, which relatives? ________________________

Is there a family history of other types of skin cancer? Y N

Would you like to discuss any of the following cosmetic concerns? Y N

Forehead wrinkles, "11's" between eyebrows, crow's feet	Uneven skin tone or hyperpigmentation on the face	Broken blood vessels or redness on face
Smile lines and marionette lines	Brown spots & "age spots"	Unwanted hair on face or body
Flattening of the cheeks	Large pores	Hair loss or thinning
Thinning lips	Acne scarring	Thinning of eyelashes
Downturned corners of mouth	Sagging jowls	Tired look, dark circles under eyes

Medications: Please enter all prescription medications

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Allergies: Please enter all medication allergies

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Social History: Check all that apply

Currently Smokes Former Smoker Drugs Alcohol Other

Review of Systems: Check all that apply

Problems with bleeding	Skin rash	Muscle aches
Problems with healing	Fever or chills	Joint pain
Problems with scarring / keloids	Unexplained weight loss	Hay fever

Alerts: Check all that apply

Pacemaker	Allergy to lidocaine	Pregnancy
Defibrillator	Allergy to bacitracin/Neosporin	Planning a pregnancy
Joint replacement (within 2 years)	Allergy to latex	Breastfeeding
Artificial heart valve	Allergy to adhesive	
Premedication prior to procedure	Rapid heart beat with epinephrine	

PATIENT SIGNATURE: ______________________________ **DATE:** ____________________