NEW PATIENT/FIRST OFFICE VISIT FORM

Directions: Please fill in the blanks &check all that apply. Write" NA" in any sections that are "not applicable" to your visit.

Patient Name: ____________________ Date of Birth: ____________________

Your Pharmacy Name: ____________________ Your Pharmacy Location: ____________________

Were you sent to our office by another Physician of whom you would like us to send your records? ☐ Yes ☐ No

If Yes; Please list Physician Name: ____

Should we be expecting outside records from another office about your visit? ☐ Yes ☐ No

ARE YOU COMING TO SEE US PRIMARILY FOR A SKIN/MOLE CHECK? ☐ Yes ☐ No
We offer a complete skin check to all patients. For many, especially adults, this should be repeated once each year.
Would you like a complete skin check today-this would require you to put on a gown? ☐ Yes ☐ No
Please note that if we will be examining areas you normally cover with makeup, the makeup should be left off or removed prior to the provider examining you.

WHAT IS/ARE THE REASON (S) FOR THIS VISIT? ____

WHERE IS/ARE THE PROBLEM(S) LOCATED? ____

WHEN DID YOUR CONDITION START? ____

WHAT MAKES YOUR CONDITION WORSE? ____________________ BETTER? ____________________

WHAT ARE YOUR PREVIOUS PRESCRIPTIONS AND/OR OVER-THE-COUNTER TREATMENTS YOU HAVE PREVIOUSLY TRIED *FOR THIS CONDITION*? (Please list exact names and note if any have helped this condition)

____

____

SYMPTOMS FOR THIS CONDITION: (rate when they are at their worst on 1-10 SCALE, 10 IS WORST)
☐ Itch NA 1 2 3 4 5 6 7 8 9 10 ☐ Burn/Sting NA 1 2 3 4 5 6 7 8 9 10 ☐ Pain NA 1 2 3 4 5 6 7 8 9 10
PLEASE LIST YOUR ALLERGIES AND DRUG REACTIONS: ☐ None (or) ____________________
PLEASE LIST YOUR ENVIRONMENTAL ALLERGIES: ☐ None (or) ____________________

CURRENT MEDICATION(S) Please include vitamins/supplements, over-the-counter and any creams/ointments:

____

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____

____

YOUR PAST MEDICAL HISTORY

☐ Melanoma Skin Cancer—dates/locations on body: ____

☐ Basal Cell Skin Cancer—dates/locations: ____

☐ Squamous Cell Skin Cancer—dates/locations: ____

☐ Anemia	☐ Alcoholism	☐ Anxiety	☐ Arthritis
☐ Chronic lung disease	☐ Crohn's or Colitis	☐ Dementia	☐ Depression
☐ Dermatitis/eczema	☐ Diabetes	☐ Elevated cholesterol	☐ Glaucoma
☐ Headache	☐ Heart Disease	☐ Hepatitis/liver disease	☐ Hypertension
☐ Multiple Moles	☐ Multiple Sclerosis	☐ MRSA	☐ Pacemaker or defibrillator
☐ Prostate disease	☐ Psoriasis	☐ Seizure disorder	☐ Serious infections
☐ Sexually transmitted disease		☐ Stomach ulcers	☐ Stroke
☐ Thyroid disease	☐ Tuberculosis	☐ Other psychiatric disorder	

☐ Other Cancer --type and dates: ____

☐ Major Surgeries: ____

Females Only

☐ Pregnant ☐ Planning Pregnancy ☐ Breast feeding ☐ Using birth control

Birth Control Method: ________________________ Number of pregnancies/births: _____ /______

HAVE YOU HAD ANY OF THESE OTHER PROBLEMS RECENTLY?

☐ Reduced appetite/energy	☐ New or changing moles	☐ Planning pregnancy, pregnant, or breastfeeding
☐ Headache	☐ Joint pain/back pain	☐ Changes in memory/concentration
☐ Allergies	☐ Cough	☐ Intolerance to hot/cold environments
☐ Sore throat	☐ Shortness of breath	☐ Excessive thirst or urination
☐ Chest pain	☐ Irregular heart beat	☐ Changes in mood or anxiety level
☐ Belly pain	☐ Diarrhea/constipation	☐ Burning with urination/blood in urine
☐ Blood in stools	☐ Nausea or vomiting	☐ Weight gain or loss (more than 10 pounds)
☐ Numbness or tingling	☐ Difficulty moving arms/legs	☐ Changes in vision/hearing/smell/taste

If you have had any of these problems recently, please give more details (when, where, how, etc.) __________________

____

FAMILY HISTORY (your immediate family only, ie; your brothers, sisters, parents, or children)

☐ Melanoma skin cancer (in whom____)

☐ Basal cell or squamous cell skin cancer (in whom_______________________________________)

☐ Multiple sclerosis	☐ Crohn's or Colitis	☐ Liver disease
☐ Depression	☐ Anxiety	☐ Psychiatric disease
☐ Suicide	☐ Psoriasis	☐ Eczema (dermatitis)
☐ Seasonal allergies	☐ Asthma	☐ Lupus or rheumatoid arthritis

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No

Your occupation____

Your personal interests (hobbies)____