Dermatology Associates at Crystal Run

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NEW PATIENT HEALTH HISTORY FORM

Today's Date: ________________

Name ______________________________ ______________________ ________ Date of Birth: ________________
Last *First* *Middle Initial*

Please describe the reason for your visit today: ____

____

____

Have you been to our office before? NO YES *As a Patient* *With a Friend* *With a Family Member*

Are you allergic to any medications? NO YES *If yes, please list, and describe what happens when you take this medication:*

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____

Are you currently taking any medications? NO YES *If yes, please list:*

____

____

Are you currently taking any supplements or over-the-counter medications? NO YES *If yes, please list:*

____

____

Do you smoke? NO YES QUIT

Are you pregnant? NO YES Are you breast-feeding? NO YES

Do you have any medical conditions / illnesses? NO YES *If yes, please list:*

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____

Have **you** ever had SKIN cancer? NO YES What *Type?* Basal Cell Carcinoma Squamous Cell Melanoma

Have any **family members** had SKIN cancer? NO YES Relationship (mother, father, sibling, etc.) ________________________

What *Type?* Basal Cell Carcinoma Squamous Cell Melanoma

Have you ever had any kind of surgery? NO YES *If yes, please list:*

Date: ____________________ Surgery: ____

Date: ____________________ Surgery: ____

May we CALL you with lab results? YES NO Phone #: ____________________

May we EMAIL your lab results? YES NO Email: ________________________________

May we call you at work / cell phone? YES NO Work phone#: ________________ Cell#: ________________

Is it okay to leave a message on your voice mail or answering machine? NO YES

Is it okay to speak with another person regarding your SKIN condition? NO YES

If yes, please list name(s) ____

Who referred you to our office? ____