Dermatology Specialists of Spokane New Patient Medical History Form

Date: ____/____/____ **Name:** _____ **DOB:** ____/____/____

Best contact number: _____ **Ok to leave a message: Y / N**

Referring Provider: (Name/Phone) _____

Preferred Pharmacy: (Name/Phone) _____

Reason for today's visit: _____

Symptoms of your current skin condition (please circle): Bleeding Itching Painful Growing Changing

Duration of skin condition: _____

Have you tried any medications for this current condition? Y N

If Yes, please list: _____

Have you had the Pneumonia vaccine? Y N

For females: Having periods? Y N Are periods regular? Y N Are you pregnant? Y N

Personal Past Medical History or Current Diseases:

Skin Cancer	Y N	HIV/ AIDS	Y N
Actinic Keratosis	Y N	Hepatitis C / Liver Disease	Y N
Melanoma	Y N	Thyroid Disorders	Y N
Cancers	Y N	Diabetes	Y N
Psoriasis	Y N	Childhood eczema / Eczema	Y N
Seasonal allergies / hay fever	Y N	High Blood Pressure	Y N
Keloids	Y N	Pacemaker / Defibrillator	Y N
Autoimmune Disease	Y N	Arthritis / Artificial joints	Y N

If you answered **YES** to any of the above, please explain: _____

Other major medical illnesses / surgeries: _____

Family History: If any blood relative has any condition listed below, check and specify which blood relative {Ex: (x) Mother/Father/Sister/Brother/Child}

Allergies/ Hay Fever ( ) _____ Severe Acne ( ) _____ Other Cancer ( ) _____

Eczema ( ) _____ Psoriasis ( ) _____ Heart Disease ( ) _____

Asthma ( ) _____ Diabetes ( ) _____ High Blood Pressure ( ) _____

Hives ( ) _____ Skin Cancer ( ) _____ Autoimmune Disease ( ) _____

Social History:

Tobacco use: Current Former Never

Alcohol Use: Current Former Never

Ethnicity: (optional) _____

Relationship Status: (optional) Single Married Other

Occupation: _____

Allergies (Medications, latex, food): _____

Current Medications: _____

_____

Review of systems: *Are you having any of these symptoms today? ( ) YES ( ) NO If YES, please circle:*

Fevers, Chills, Nausea, Vomiting, diarrhea, constipation, chest pain, shortness of breath, cough, headaches, numbness, Joint pain, vision changes, unintended weight loss, anxiety, depression, easy bruising / bleeding