New Patient Information

Full Name ____ Date ___________________

(as it appears on legal documents / driver's license)

Address ____

City _________________________________ State _____________ Zip ________________

Email address _______________________________ SS# ____________________________

Home phone ____________________________Business phone/cell______________________

May we contact you at home or work? ________________ May we leave a message? _____________

Date of Birth _______________ Age_________ Male ___ Female ___Marital Status_______________

Height ________ Weight (lbs) ________ Number of Children _________

Race: Caucasian____ African American____ Hispanic____ Asian____ Other____________________

Emergency Contact: Name____

Phone___________________________ Relationship ____________________________________

How did you hear of our office? Friend ____ Friend's Name__________________________

TV ____ Radio ____ Station____________ Website____ Which Website? ________________

Newspaper___ Magazine ___ (Which Magazine? ____

Yellow Pages ___ Other____ (If other, explain ____

How much time do you spend in the sun? _________________ Tanning booth?___________________

Do you wear sunscreen? _________ How often? ______________ SPF/Brand __________________

How would you describe your skin?

____Always burn, never tan ____Sometimes burn, always tan

____Always burn, sometimes tan ____Never burn, always tan

Do you have any skin allergies or hypersensitivity? If yes, explain ______________________________

____

What products are you currently using on your face? _____________________________________

Have you had a chemical peel? _________ Type? ________________ When? __________________

Have you had a laser treatment? ________ Type? _______________ When? ___________________

Who is your primary care physician? ____

Is a physician currently treating you (for any reason)? _________________________________

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcomed to a copy of the report if you wish. There is room to explain your answers more completely on the back of the second page. **Please Type or Print.**

NAME: ______________________________ **DATE OF BIRTH**:____________________

Last First M

ADDRESS (CITY,ST) ______________________________ **OCCUPATION** ______________________

PHARMACY PREFERENCE (LOCATION):______________________ **PHONE**____________________________

PURPOSE FOR VISIT: What is the main reason you are seeing the doctor today?

____

____

MEDICATIONS

Please list any medications ***including aspirin, vitamins, over-the-counter, or herbal medication***?

Medication Name	***Dose***	***How Often Taken***

ALLERGIES

Medication Name	***Type of Reaction***
Do you have environmental Allergies?	☐**Yes** ☐**No** Please list:
Do you have food Allergies?	☐**Yes** ☐**No** Please list:
Do you have a known allergy to Latex?	☐**Yes** ☐**No**

PAST MEDICAL HISTORY ***Have you ever been DIAGNOSED with any of the following problems?***

	Yes	**No**	**Year**	**Comment**
CANCER (please list type):	❐	❐		
Cardiovascular				
Do you have a pacemaker	❐	❐		
High/Elevated Cholesterol	❐	❐		
High Blood Pressure	❐	❐		
Other Heart Problems	❐	❐		
Respiratory				
Asthma	❐	❐		
COPD	❐	❐		
Tuberculosis	❐	❐		

NAME: ____ **Date of birth**: ________________________

PAST MEDICAL HISTORY *Continued*

	Yes	No	Year	Comment
Gastrointestinal				
Hepatitis	❐	❐		
Reflux	❐	❐		
Stomach ulcers	❐	❐		
Kidney				
Renal Failure	❐	❐		
Mental and Emotional				
Depression (requiring treatment)	❐	❐		
Anxiety (requiring treatment)	❐	❐		
Hematologic/Immunity				
Anemia	❐	❐		
HIV/AIDS	❐	❐		
Mononucleosis	❐	❐		
Bleeding after surgery	❐	❐		
Blood transfusion	❐	❐		
Other Not Listed Above				
Problem:	❐	❐		

GYNECOLOGIC HISTORY *(Women, please complete the following)*

	Yes	No	Comment
Menses/Pregnancies/Births			
Could you be pregnant?	❐	❐	
Date of last menstrual period:	___/____/___		
How many pregnancies have you had?	#____________		
How many live births have you had?	#		
Nursing			
Are you nursing?	❐	❐	
How many months total have you nursed?	#	months	
Hormone Replacement			
Have you ever taken Estrogen?	❐	❐	
Number of years taking Estrogen?	#	years	
Breast Health – Have you ever had:			
bloody nipple discharge?	❐	❐	
Non-bloody nipple discharge?	❐	❐	
Injury to breasts?	❐	❐	
Breast infections?	❐	❐	
Pain in breasts?	❐	❐	
Breast biopsy?	❐	❐	
Breast Cancer Risk Profile:			
Do you consider yourself:			
• Caucasian/non-black	❐	❐	
• Hispanic	❐	❐	
• Black	❐	❐	
When was your last mammogram?	_____________		
Age of first menses?	_____________		
Age at first live birth?	_____________		
Number of mother/sisters/daughters with Breast cancer:	_#___________		
Number of previous breast biopsies:	_#___________		
Biopsy with atypical hyperplasia?	❐	❐	

NAME: ______________________ **Date of birth**: ______________

PAST HOSPITALIZATIONS

Have you ever been hospitalized for a medical problem before? ☐ **Yes** ☐ **No** Please list below:

Year	Reason for Admission	Date	Physician

PAST SURGICAL HISTORY

Year	Procedure	Surgeon

ANESTHESIA HISTORY

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ **Yes** ☐ **No**

If yes, please indicate which type of anesthesia and check reaction(s) below:

	Reaction	
☐ General Anesthesia	☐ No Problems	☐ Nausea ☐ Vomiting ☐ Slow Awakening ☐ Difficult Intubation ☐ Other
☐ IV Sedation	☐ No Problems	☐ Nausea ☐ Vomiting ☐ Slow Awakening ☐ Other
☐ Epidural/Spinal	☐ No Problems	☐ Nausea ☐ Vomiting ☐ Bleeding ☐ Headache ☐ Other
☐ Regional Block	☐ No Problems	☐ Insufficient ☐ Prolonged ☐ Systemic Reaction ☐ Other
☐ Local	☐ No Problems	☐ Insufficient Block ☐ Heart Palpitations ☐ Systemic Reaction ☐ Other

Comments:

FAMILY HISTORY *Please mark all that apply:*

					Maternal		Paternal	
	Mother	**Father**	**Brother**	**Sister**	**Grandmother**	**Grandfather**	**Grandmother**	**Grandfather**
Specific Anesthesia problem	❒	❒	❒	❒	❒	❒	❒	❒
CANCER (please list type) under check mark	❒	❒	❒	❒	❒	❒	❒	❒
Cardiovascular:								
High Blood Pressure	❒	❒	❒	❒	❒	❒	❒	❒
Heart Problems	❒	❒	❒	❒	❒	❒	❒	❒
Respiratory:								
Asthma	❒	❒	❒	❒	❒	❒	❒	❒
Lung Cancer	❒	❒	❒	❒	❒	❒	❒	❒
Neurologic:								
Stroke	❒	❒	❒	❒	❒	❒	❒	❒
Hematologic								
Bleeding/clotting problem	❒	❒	❒	❒	❒	❒	❒	❒

SOCIAL HISTORY

Have you ever smoked? Do you smoke now?	☐ **Yes** ☐ **Yes**	☐ **No** ☐ **No**	Comments (indicate amount per day):
Do you drink alcohol?	☐ **Yes**	☐ **No**	Comments (indicate amount per week):
Do you use any recreational drugs?	☐ **Yes**	☐ **No**	Comments (indicate frequency):

NAME: ______________________________________ **Date of birth**: _______________________

REVIEW OF SYSTEMS ***Have you RECENTLY had any of the following problems?***

	Yes	No	Comment
General Health Problems:			
Fever	❒	❒	What is your current Height: __________ Weight: ________
Chills	❒	❒	
Night Sweats	❒	❒	
Weight Loss/Gain > 10 lbs/1 month	❒	❒	
Fatigue	❒	❒	
Head/Neck Problems:			
New Headache	❒	❒	
Vision/Eye problems	❒	❒	
Earache, loss of hearing	❒	❒	
Chronic sinus infections	❒	❒	
Cardiovascular Problems:			
Blacking out/Fainting	❒	❒	
Bluish discoloration of lips/fingernails	❒	❒	
Chest pain	❒	❒	
Irregular heartbeat/palpitations	❒	❒	
Swelling of ankles	❒	❒	
Respiratory Problems:			
Frequent non-productive cough	❒	❒	
Frequent productive cough	❒	❒	
Shortness of breath	❒	❒	
Short of breath climbing 1 flight of stairs	❒	❒	
Wheezing	❒	❒	
Gastrointestinal Problems:			
Difficulty swallowing/food sticking in throat	❒	❒	
Abdominal pain	❒	❒	
Constipation	❒	❒	
Diarrhea	❒	❒	
Heartburn	❒	❒	
Nausea	❒	❒	
Vomiting	❒	❒	
Blood in stools	❒	❒	
Black, tar-like stools	❒	❒	
Neurologic Problems:			
Numbness	❒	❒	
Tingling	❒	❒	
Seizures	❒	❒	
Weakness	❒	❒	
Urologic Problems:			
Blood in urine	❒	❒	
Difficulty starting urine stream	❒	❒	
Burning	❒	❒	
Leaking of urine	❒	❒	
Mental and Emotional Problems:			
Depression (requiring treatment)	❒	❒	
Anxiety (requiring treatment)	❒	❒	
Endocrine Problems:			
Feel cold all the time	❒	❒	
Feel hot when others do not	❒	❒	
Increased appetite	❒	❒	
Diabetes	❒	❒	
Thyroid deficiency	❒	❒	
Thyroid excess	❒	❒	
Hematologic Problems:			
Swollen Lymph Nodes	❒	❒	
Bruising easily	❒	❒	
Bleeding into joints	❒	❒	
Skin Problems:			
Itching	❒	❒	
Rash	❒	❒	

Signature: ____ **Date:**_________________________