Mt. Lebanon Dermatology Associates - New Patient Medical History **DATE: _____ / _____/ _____**

Name: (Last) _____ (First) _____ Referring Doctor: _____

Date of Birth: **_____ / _____/ _____** Immediate family member treated here: _____

1. **Drug Allergies**: ___ No ___ Yes List: _____
2. **Vaccines (list date)**: FLU _____ SHINGLES _____ PNEUMONIA: _____
3. **Medication List:** (include herbals, over the counter products and products used on the skin)

_____ _____ _____

_____ _____ _____

_____ _____ _____

4. **Past Medical History: Check all current and past**

( ) NONE
( ) Acne scarring
( ) Allergies
( ) Anxiety
( ) Arthritis
( ) Arthritis, Osteo
( ) Arthritis, Rheumatoid
( ) Asthma
( ) Cancer (non-skin)
A. Type: _____

Cancer (skin)
( ) BCC
( ) SCC
( ) Melanoma
( ) Celiac Disease
( ) Depression
( ) Diabetes
( ) Diet Counseling
( ) Eczema
( ) Exercise Counseling
( ) Heart Disease)

( ) Hepatitis
( ) High Blood Pressure
( ) High Cholesterol
( ) HIV
( ) Hyperthyroidism
( ) Hypothyroidism
( ) Lung Disease
( ) Lupus
( ) Psoriasis
( ) Smoking Cessation Class
( ) Other: _____

5. Past Surgical History
(Check past operations)
( ) Appendectomy
( ) C-Section(s)
( ) Gallbladder
( ) Heart Bypass Surgery
( ) Hernia Repair
( ) Hip Replacement
( ) Hysterectomy ( ) Partial ( ) Total
( ) Knee Replacement
( ) Skin Cancer Surgery
( ) Tonsillectomy
( ) Other _____

5. **Review of Systems:** **Have you recently experienced any of the following? (If yes, check and explain)**

General Health
( ) A. Fever _____
( ) B. Weight gain _____
( ) C. Weight loss _____
( ) D. Fatigue _____

Eyes
( ) A. Dry eyes _____
( ) B. Gritty sensation _____

Ear, Nose, Throat
( ) A. Dry mouth _____
( ) B. Hearing loss _____

Cardiovascular
( ) A. Swelling of feet _____
( ) B. Swelling of legs _____
( ) C. Calf pain _____

Stomach-Bowel
( ) A. Bloody stools _____
( ) B. Diarrhea _____
( ) C. Gas _____
( ) D. Bloating _____
( ) E. Nausea _____

GU-Kidney
( ) A. Frequent urination _____
( ) B. Burning with urination _____
( ) C. Bloody Urine _____

Arthritis/Muscles/Joints
( ) A. Joint pain _____
( ) B. Muscle pain _____
( ) C. Muscle weakness _____

Psychological Disorders
( ) A. Stress _____
( ) B. Anxiety _____
( ) C. Panic attacks _____
( ) D. Depression _____

Endocrine Diseases
( ) A. Increased thirst _____
( ) B. Heat intolerance _____
( ) C. Cold intolerance _____
( ) D. Change in hair or nails _____

Allergy/Immunology
( ) A. Itchy, watery eyes _____
( ) B. Runny nose, wheezing _____

6. **Family Medical History: (check answers)**

	Father	Mother	Brother	Sister
Acne, scarring	( )	( )	( )	( )
Arthritis	( )	( )	( )	( )
Asthma	( )	( )	( )	( )
Cancer (not skin cancer)	( )	( )	( )	( )
Diabetes	( )	( )	( )	( )
Eczema	( )	( )	( )	( )
Hair loss	( )	( )	( )	( )
Hay fever / Allergies	( )	( )	( )	( )
Heart Disease	( )	( )	( )	( )
High Blood Pressure	( )	( )	( )	( )
Lung Disease	( )	( )	( )	( )
Lupus	( )	( )	( )	( )
Melanoma	( )	( )	( )	( )
Other skin cancer	( )	( )	( )	( )
Psoriasis	( )	( )	( )	( )
Thyroid disorder	( )	( )	( )	( )

7. Females Only: (check or write answers)

Are you pregnant? ( ) Yes ( ) No
Breastfeeding? ( ) Yes ( ) No
Are you menopausal? ( ) Yes ( ) No
Are your periods regular? ( ) Yes ( ) No
If no, explain: _____
Birth control method: _____

8. Social History

Marital status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed
Occupation: _____
Are you a smoker? ( ) Yes ( ) No ( ) Former
If yes, how many packs per day? _____

9. Sun Exposure: (circle answers)

Amount: (Minimum) (Moderate) (Excessive) (Work Outside)
History of sunburn: (None) (Childhood) (Teens) (Adult) (Last Yr)
Hx of blistering: (I have blistered) (I have not blistered)
Sunscreen use: (don't use) (SPF 8-15) (SPF 15-30) (30+)