__ New Pt __ Update

# Phoebe Rich Dermatology

Phoebe Rich, MD Anna Hare, MD Jill Moore, MD Amy Simpson, PA-C

**2565 NW Lovejoy Suite 200 Portland, OR 97210 503-226-3376**

Name________________________________________ Today's Date________________

Preferred pronouns ______________________________________ Age________________

▪**Purpose of today's visit:** ____________________________________________________

▪**Who were you referred by?** __________________________________________________

▪**Who is your primary care doctor?** ____________________________________________

**Please list medications or attach current medication list:**

| Current Medications | Approximate Start Date | Reason for taking medication |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

▪ **Do you have a PERSONAL HISTORY of pre-cancerous skin lesions (actinic keratoses) or skin cancer (basal cell carcinoma, squamous cell carcinoma or melanoma?** □ YES □ NO

If yes, please list skin cancer type(s) location, and approximate date of diagnosis:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

▪ **Please list any OTHER HEALTH CONDITIONS you have. Include skin conditions, cancer, diabetes, heart disease, autoimmune disease, bleeding/clotting problems, depression/anxiety, etc.**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

***For females:*** **Are you or is there any chance that you might be pregnant?** □ YES □ NO

Are you nursing? □ YES □ NO

▪ **Do you have any MEDICATION ALLERGIES (ex antibiotics, lidocaine, epinephrine, latex)?**

□ YES □ NO KNOWN MEDICATION ALLERGIES

If yes, please list the name of medication and type of reaction you experienced:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

▪ **Please list all significant SURGERIES AND HOSPITALIZATIONS and approximate dates:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

▪ **Do you have a FAMILY HISTORY of melanoma?** □ YES □ NO

If yes, please list relationship of family member (s) who had melanoma:

______________________________________________________________________________

**Sun History:**

▪ How much sun exposure have you had? □ MINIMAL □ MODERATE □ EXTREME

▪ Have you ever had a blistering sunburn? □ YES □ NO

▪ Tanning bed use? □ YES □ NO □ History of tanning bed use

▪ Sunscreen Use: □ Daily □ Sometimes □ When going outdoors □ Other ______________

▪ **Smoking habits:** □ Currently a smoker □ Former smoker □ Never smoked

▪ **Recreational drug use? ____________________** ▪ **Medicinal marijuana use? ________________**

▪ **What is your occupation? ___________________** ▪ **Where did you grow up? _________________**

▪ **Have you RECENTLY experienced any of the following (within past few months)?**

| | No | Yes | | No | Yes | | No | Yes |
|---|---|---|---|---|---|---|---|---|
| Fever | | | Vision changes | | | Joint Pain | | |
| Weight change | | | Cough | | | Edema | | |
| Fatigue | | | GI upset | | | Swollen Glands | | |
| Mood changes | | | Difficulty Urinating | | | Heavy/Irregular Periods | | |
| Headache | | | Muscle aches | | | Other Health Concerns | | |

If you checked yes, please explain:______________________________________________________

______________________________________________________________________________

Patient Signature_________________________ MD/PA Signature____________________________