

__ New Pt __ Update

Phoebe Rich Dermatology

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Name _____ Age _____ Today's Date _____

▪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 _____