LENZY DERMATOLOGY
GENERAL • COSMETIC • PEDIATRIC

New Patient Medical History Form

Name: _____ **Date of Birth:** _____

Primary Care Physician (Name/Address/Phone/Fax): _____

_____

Reason for today's visit: _____

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

Duration of skin condition: _____

Have you tried any medications in the past for your current condition? Y N

If Yes, please list:

_____

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

_____

Personal Past Medical History or Current Disease(s):

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
Cancer (other than skin cancer)	Y	N	Diabetes	Y	N
Psoriasis	Y	N	Kidney disease	Y	N
Childhood eczema	Y	N	High Blood Pressure	Y	N
Seasonal allergies or hay fever	Y	N	Heart Attack or Stroke	Y	N
Asthma	Y	N	Artificial Heart Valve	Y	N
Keloid	Y	N	Pacemaker/ Defibrillator	Y	N
Anesthetic Complications	Y	N	Organ/Bone Marrow transplant	Y	N
Autoimmune Disease	Y	N	Artificial Joint within 6 months	Y	N

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

Other major medical illnesses/surgeries: _____

Family History: If any blood relatives has or have had any conditions listed below, check and specify which blood relative
[ex: (✓) Mother/Father/Sister/Brother/Child/Uncle/Aunt/Grandparent]

Allergies/Hay Fever	( ) _____	Severe Acne	( ) _____	Other Cancer	( ) _____
Childhood Eczema	( ) _____	Psoriasis	( ) _____	Heart Disease	( ) _____
Asthma	( ) _____	Diabetes	( ) _____	High Blood Pressure	( ) _____
Hives	( ) _____	Skin Cancer	( ) _____	Autoimmune Disease	( ) _____
Rosacea	( ) _____	Melanoma	( ) _____		

Social History:

Ethnicity: _____

Tobacco Use: Current Former Never

Alcohol Use: Current Former Never

Relationship Status: Single Married Other: _____

Occupation: _____

Allergies (medications, latex, food): _____

Current Medications (Prescribed, Supplements/Herbs, Non-Prescribed): _____

_____

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, changes in vision, unintended weight loss, anxiety, depression, easy bruising/bleeding, painful urination**