LENZY DERMATOLOGY
GENERAL • COSMETIC • PEDIATRIC

New Patient Medical History Form

Date:_____/_____/_____ **Name:** _____ **DOB:**_____/_____/_____

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 relative has any condition 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:

Tobacco Use: Current Former Never

Alcohol Use: Current Former Never

Ethnicity: _____

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