Commonwealth Dermatology, P.C.
General Dermatology
New Patient Questionnaire

Today's Date ________________________ Chart Number_________
Name ________________________ DOB________________

Past Medical History: Please circle Y (yes) or N (no) and briefly explain if you or an immediate family member have had a condition that is not listed.

You	Family Member		You	Family Member	
Y/N	Y/N	Asthma	Y/N	Y/N	Eczema
Y/N	Y/N	Allergies/hay fever	Y/N	Y/N	Blood transfusions
Y/N	Y/N	Heart disease	Y/N	Y/N	Women: pregnant or nursing
Y/N	Y/N	Stroke / TIA	Y/N	Y/N	Transplanted organ
Y/N	Y/N	Pacemaker / defibrillator	Y/N	Y/N	Bleeding Disorder
Y/N	Y/N	HIV / AIDS	Y/N	Y/N	Tattoos (professional, amateur, ____________)
Y/N	Y/N	Diabetes	Y/N	Y/N	Psoriasis
Y/N	Y/N	Kidney disease	Y/N	Y/N	Other medical conditions, explain. ________________
Y/N	Y/N	Lung disease / emphysema	Y/N	Y/N	Other skin disorders, explain. ___________________
Y/N	Y/N	Tuberculosis	Y/N	Y/N	Any other cancer, explain. _____________________
Y/N	Y/N	Liver disease / cirrhosis _______________			
Y/N	Y/N	Hepatitis B _________________________			
Y/N	Y/N	Hepatitis C _________________________			

Pediatric History (if applies)

Pre- or Full Term? ______________________
Any complications with delivery? _____________
Any complications after birth? _______________
Child home from hospital with you? ___________
Up to date on immunizations? _______________
Breast fed or formula? ______________________________
Normal growth and development? _____________________
Developmental delays? _____________________________
Current Milestones _________________________________
Last check up? ____________________________________

Surgical History

YES NO Have you had surgery? If yes, please indicate what kind and when.
____
____
YES NO Do you require antibiotics or other medication prior to dental or surgical procedures?

Social History

YES NO Do you wear sunscreen?
YES NO Do you smoke? If yes, how much and for how long?_______________________________
YES NO Do you drink alcohol? If yes, how much?____
YES NO Do you use illicit drugs?

Skin Cancer History

You	Family Member	
Y/N	Y/N	Do you have a family history of basal cell carcinoma?
Y/N	Y/N	Do you have a family history of squamous cell carcinoma?
Y/N	Y/N	Do you have a family history of melanoma?

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Patient Name ______________________________ Chart Number __________________

Review of Systems: Please indicate Y (yes) or N (no) for each.

General

Y/N Fever
Y/N Chills
Y/N Nausea
Y/N Fatigue
Y/N Weight loss
Y/N Night sweats
Y/N Vomiting
Y/N Pregnant or nursing

Heme

Y/N Excessive bleeding
Y/N Easy bruising
Y/N Anemia
Y/N Chemotherapy
Y/N Leukemia

Immunology

Y/N Frequent infections
Y/N Herpes simplex (cold sores)
Y/N Herpes zoster (shingles)
Y/N Immunodeficient (other, specify ___________)

Cardiac

Y/N Chest pain
Y/N Leg swelling
Y/N Shortness of breath
Y/N Palpitation

Musculoskeletal

Any difficulty with movement that would affect your ability to lie on an exam room table? Y/N
Y/N Joint pains

Allergies: List all allergies and any associated reactions.
____
____

__________ **Check here if none of these apply**

Patient or responsible party's signature ___________________________________ Date ______________________________

FOR PROVIDER USE ONLY

Initial review completed:

Initials / date of sub. review and update: