NEW PATIENT MEDICAL INFORMATION
TRIBECA PARK DERMATOLOGY

Patient Name:_____

Reason for Visit:_____

Medical History Height_____ Weight_____

Medical Conditions (past and present):_____

Medications:_____

_____

Allergies to Medication?:_____

For women: Are you pregnant?_____Breast Feeding?_____

Skin History

Do you have a personal history of skin cancer, atypical moles, or precancerous skin growths?:_____

If "yes" what type and location:_____

Describe any past skin issues (such as eczema, psoriasis, acne,etc):_____

Family History

Family history of skin cancer?:___If "yes" please provide details _____

List any family history of skin conditions (such as eczema, psoriasis, acne, etc)?:_____

Social History

Cigarette Smoking History (please check any that apply):

_____ **Never a smoker** ____ F**ormer smoker** ____ **Current daily smoker** ____**Current smoker some days**

Alcohol Consumption

How many times in the last year have you had 5 drinks or more in a single night?(circle one) **0 1-12 >12**

Sun Exposure

Would you describe your past sun exposure as: Low_____ Moderate_____ High_____

Current Symptoms: (Check all that apply)

___ fever/chills	___ congestion/allergies	___ joint pain
___ significant change in weight	___ chest pain/pressure	___ muscle weakness
___ changes in vision	___ swelling of extremities	___ loss of sensation
___ changes in hearing	___ cough	___ headaches
___ earaches	___ shortness of breath	___ anxiety/depression
___ mouth sores	___ abdominal pain	___ easy bruising
___ nose bleeds	___ nausea/vomiting	___ lymph node swelling
___ sore throat	___ genitourinary symptoms	___ temperature intolerance

Signature of Patient:_____Date:_____